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## CLARA THOMPSON

1893 — 1958

CLARA THOMPSON died on December 20, 1958. Typically, she was active professionally until the last two weeks. The daughter of a New England family, she started out in life intending to become a medical missionary. In her psychiatric training, she worked at Phipps Clinic where she was most highly regarded by Adolf Meyer. In the early Thirties, she went to Budapest and started analysis with Dr. Ferenczi.

With a gift for seeing behind the verbiage of the field, she became one of the important figures in the modification of psychoanalytic thinking. The lucidity and clarity of her style often belied the complicated thinking behind it. She had a wide range of professional interests, as evidenced by her many papers. A tireless clinician, she has many former analysands in many institutes. Her lack of dogmatism is evidenced by the many friends she had in psychoanalytic and psychiatric societies.

Closely associated with Harry Stack Sullivan and Frieda Fromm-Reichmann, she was a Fellow of the Washington School of Psychiatry and had been a member of the Board of Trustees of the William Alanson White Foundation since 1943. For years, she made week-end trips to Washington in order to participate in the teaching and training of students there. During the week, she was active in New York as the Executive Director of the William Alanson White Institute of Psychiatry, Psychoanalysis and Psychology. She, along with Sullivan, Fromm, Fromm-Reichmann, and Rioch, started this Institute as a successor to the New York Division. Clara Thompson, in her unassuming way, was active as teacher, training analyst, supervising analyst, personal therapist and administrator. She wrote over thirty papers, one book, and edited another in collaboration with Dr. E. Witenberg and Dr. M. Mazer.

With her death, the American psychoanalytic scene has lost one of its more significant figures in the quest for open-mindedness and clarity.

# DYNAMICS OF HOSTILITY

## A PANEL DISCUSSION

FREDERICK A. WEISS, Moderator

OUR VIEW of the dynamics of hostility is changing. The change reflects the basic transformation our concept of human nature has undergone in the first part of this century. Psychoanalysis for a long time saw hostility as an innate aspect of human nature, first, as accompanying certain phases in the development of the libido in the form of oral or anal sadism; later, after the first World War, Freud described "the tendency to aggression as an innate, independent, instinctual disposition in man."<sup>1</sup> Directed against others or the self, it was considered the expression of the ubiquitous death instinct.

Libido and the death instinct were seen as co-existing in a state of "fusion." When was aggression and hostility released or—to use instinctivistic terminology—when did the "defusion" take place? The answer to this question brought a new factor into the foreground of psychoanalytic thought: frustration. This meant a step forward because frustration put beside the factor of the innate that of the environment with which the individual interacts and made it possible to conceive

of hostility as a reactive, a secondary phenomenon. But what was seen as being frustrated? Libido. Energy is transferred from libido to the aggressive drive. Thus a preconceived theory limited the potential value of the new formulation.

In the holistic view of modern biology (Kurt Goldstein, Julian Huxley), man is more than a bundle of instincts; he is a living whole that interacts with the whole of the environment. In the dynamics of hostility are involved not only his relationship to the environment, to others, but also his relationship to himself. Only if we include in our consideration the intrapsychic, the motivation behind the phenomenon, can we avoid a confusion which, in my opinion, has up to now interfered with most attempts to clarify the dynamics of hostility.

The confusion, I believe, is based on two misleading equations. The first one is: hostility equals aggression. But hostility is by no means always expressed in aggressive behavior. It is not less often shown by withholding positive emotions, such as affection or deserved

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These papers were delivered at a regular meeting of the Association for the Advancement of Psychoanalysis at the New York Academy of Medicine on April 23, 1958. Frederick A. Weiss, M.D., is President of the Association for the Advancement of Psychoanalysis. Bernard Zuger, M.D., is a practicing psychoanalyst. The late Clara Thompson, M.D., was Executive Director of the William Alanson White Institute of Psychiatry, Psychoanalysis and Psychology. Louis Landman, M.D., is a lecturer at the American Institute for Psychoanalysis. Joost A. M. Meerloo, M.D., is a member of the faculty of the New School for Social Research. Bella S. Van Bark, M.D., is a member of the American Institute for Psychoanalysis.

appreciation, or by withdrawing from relationships, or by making excessive claims which will arouse guilt in the partner, in a demanding dependency relationship.

The second misleading equation is: aggression equals hostility. This equation, which I very often found accepted as self-evident and valid in psychoanalytic discussions interferes, in my opinion, even more with our understanding of and our approach to hostility. What is lost here is the motivationally and dynamically decisive distinction between hostile aggression and healthy self-assertion.

Webster's dictionary says: "*Aggressive* means (1) being disposed to attack (as in an aggressive war), and (2) being self-assertive." This is a regrettable but not uncommon lack of clarity. It becomes, however, a dangerous factor in therapy when analysts do not clearly distinguish between hostile aggression, motivated by the wish to hurt physically or emotionally, particularly to humiliate another person, and healthy self-assertion.

To take a stand for oneself, to be healthily assertive, if our needs for growth and self-realization are frustrated or threatened, to be healthily aggressive in work, sex, or in attempts to master nature, is not hostility. Rejecting as early as 1931 the concepts of an innate drive for aggression and particularly that of a death instinct, Horney asked for a "conceptual distinction between aggression and destruction." "It is not by chance, nor looseness of expression, that Freud continuously couples these two concepts or equates them. The intimate relationship he intends to assign to them is made quite clear by the fact that he conceives of drives for domination, for power, for the mastery of nature as 'modified and

tamed, as it were, aim-inhibited expressions' of this drive for destruction."

"The constructive aim-inhibited expression of the destructive?" Horney asks. "The essential motivation for the mastery of nature would seem to originate . . . in those drives which impel us to preserve life and to improve its conditions . . . Might not all these tendencies be seen as a vital need for expansion of life? Are they not all exquisitely life-affirmative?"

Contrasting the potentials inherent in the human condition with animal nature, Horney writes: "It is true that the proverbial lioness turns savage, defending her cub; but are we faced here with malevolence, destruction, and the wish to kill—or with the wish to preserve life and to defend it. That which here leads to the actual annihilation of another living being is without a doubt determined by a drive to live. Moreover, when does an animal attack at all? When it is hungry or when it is attacked; each time in the service of self-preservation."<sup>2</sup>

Far from being, as commonly assumed, an animal heritage hostility has to be considered a specifically human characteristic. Goethe expressed this when he had Mephisto say to Faust:

"Man calls it reason, and his power  
has increased  
To be far beastlier than any beast."

Adolf Portmann, in his recent study of animal and human nature, confirms this view: "We perceive today more clearly how human is even the most gruesome brutality in our behavior. This evil no longer appears to us as the residual of the animal in us which need be overcome—as the optimistic early proponents of the theory of evolution liked to believe—but as a heavy burden of our being human. Today we are

penetrating the self-deception that referred to a 'regression' to primitive barbarism and brutality—whereas we are in reality dealing with an extreme of behavior which is a potential in all of us."<sup>3</sup>

Hostility, however, is by no means the universal human reaction to frustration, as has been stated in some recently advanced psychological theories. I agree with Horney that "the amount of frustration human beings can bear without hostility is amazing. Hostility arises only if a frustration is unfair or if, on the basis of neurotic claims, it is felt to be unfair."<sup>4</sup> I might have preferred to speak of "needs" instead of "claims."

Psychoanalytic experience shows that hostility is most frequently generated when unconscious anxiety-charged needs for power or for "total love," or for "unlimited freedom," and, mainly, for self-idealization are frustrated. Thus the main source of hostility is the frustration of symbolic or "quasi-needs," as they are called by the social psychologist. Man, the "symbolizing animal," as Cassirer<sup>5</sup> describes him, with the capacity for symbolization, acquired not only the uniquely human capacity for being productive and creative, but also the uniquely human capacity for being hostile and destructive. He experiences various degrees of hidden or open hostility whenever a private or public symbol of his self-idealization, of his group superiority (social, racial, national, religious), or of his power or prestige are threatened.

Therapy requires a clear differentiation between hostility and healthy assertion or healthy aggression. A therapist who considers hostility an extreme expression of aggression may try to "tame" the aggressive instinct in his patient. But psychodynamically seen,

hostility and healthy assertion or aggression are opposites. Assertion is based on strength and acceptance, hostility on weakness and rejection of the self. It is just the blocking of healthy assertion, as it occurs in an unhealthy early environment which does not provide full acceptance and encouragement of the child as a growing individual, that generates feelings of rejection leading to self-rejection, basic anxiety, and defensive hostility.

Hostility originates in a weak self when it feels threatened. Hidden or open hostility, therefore, is present in any symbiotic dependency relationship. The degree of hostility is proportionate to the intensity of the experienced threat. In the analytic relationship hostility is not merely due to the patient's "transferring" to the therapist hostile feelings which he harbored against significant persons in his environment. Effective therapy is continually threatening the defense structure of the patient. And while he wants to get rid of his symptoms, he anxiously clings to the status quo which, in the beginning of therapy, he sees as the only available mode of his existence. Thus the therapist is experienced not only as a friend but also as an enemy. A patient may, in a dream, kill the analyst who, in the preceding analytic hour, effectively attacked some element of the defense structure.

The potential for hostility is extremely great in the schizophrenic, whose personality structure—a fragile self with anxiety-charged needs for omnipotence and uniqueness—is particularly vulnerable. For emotional survival, this patient often has to externalize his hostility onto the therapist and the therapist needs a high capacity for tolerating hostility.

In therapy, hostility decreases with

the increasing strength of the self. The patient gradually feels less anxiety and therefore less defensive hostility when illusionary values are threatened which, in the beginning, he experienced as vitally needed to cover his basic self-rejection and to maintain his self-idealization. Growing self-acceptance provides more and more solid ground for the courage to be himself, assert himself, and realize himself.<sup>6</sup>

Similarly, hostility between nations will diminish to the degree that they shift their energies from self-glorification and self-idealization to self-realization, which means to realizing the gen-

uine creative potential in their national character.

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## BERNARD ZUGER

I take my assignment in this discussion to be two-fold: one, to describe the hostility actually seen in childhood; and, two, to see what developmental connection there may exist between the hostility in childhood and that seen later in life.

Immediately, some very serious difficulties arise. First come those of definition. Shall we, for instance, place "acting out" under hostility? The objection may well be raised that acting out may be present without any great show of emotion or inner turmoil and without adequate psychological motivation. Shall we consider suicide as hostility against oneself? What shall we do with sibling rivalry in its extreme forms? In a sense, all these manifestations could be included under acting out. There is then the question of what to do with latent hostility, ready to respond to any piper. And how shall we recognize it in a clinical study?

These and other considerations indicate the difficulty of the subject of to-

night's discussion. However, if we chose some simpler aspect of the problem with the object of allowing a more rigorous treatment, justice would not be done to the rich complexity which it presents clinically.

I thought we might get somewhat closer to the actual problem in childhood if we looked at a series of cases. For this purpose I have examined the last hundred consecutive cases seen by me either in consultation or treatment. These come about equally divided from private practice and a child-guidance clinic, and include children up to fifteen years of age.

Let us see why these children were brought to a psychiatrist and, if possible, the part that hostility played in their problem. First, an orienting overview of the hundred cases. In forty of the cases the problem was school: in twenty-four of these, it was poor work alone; in fifteen, both poor work and disturbing behavior; and in one, disturbing behavior alone. In another

forty-five the problem was mainly some disturbance with self, manifested in emotional or somatic difficulties, or difficulties in relationships with others. In the remaining sixteen the reason for referral was overt aggression against others, or others and self. You will, of course, recognize that children may be brought because of more than one problem and that classification is often difficult and somewhat arbitrary.

Let us examine the last sixteen cases first. These are all cases of acting out—mostly in relation to other children and in destructive acts. In one case it was sexual acting out against smaller children. Of no child can it be said that there was any real expression of hostility, such as we see in adults, or any apparent concern over the consequences. Often there was denial of the act, or justification on the basis of its having been provoked by the other party. In this group of cases, as has been found in more extensive studies by others, the number of broken homes was high, specifically, in seven of the sixteen cases. The number of serious disturbances in one or both parents—psychosis, alcoholism, serious disagreement without separation, and so on—was also high; another six of the sixteen cases. Among the sixteen children there was evidence or strongly suggestive evidence of brain pathology in three, retardation in one, and probably also in three others. In three of the children a diagnosis of psychosis was seriously considered.

What tentative conclusions can we draw from this group of cases? The first is that acting out in these cases, as has been mentioned for others, is not preceded by much psychological mediation. It is rather direct, impulsive, almost reflex in character. No convincing dynamics have been described for act-

ing out and, clinically, little material of a dynamic kind is generally the rule. It seems as though there were little conflict within the personality and no great build-up of psychological defenses to bridge conflicting elements.

The second conclusion we may draw at this point concerns the multiplicity of factors operating in many of these children. Unlike the situation in the case of adults, many of these children have not yet established themselves biologically before having to meet difficult environmental situations.

Now let us look at the group of forty children with school difficulties and divide it into two groups, with and without disturbing behavior, twenty-four in one and sixteen in the other. Among the twenty-four children with scholastic lags but good behavior, there were five broken or seriously disturbed homes; among the sixteen children who also behaved badly there were eight such homes. The trend is fairly clearly in line with the group first discussed, though the cases are not matched between the subgroups, and the data in other respects has not been subjected to sophisticated statistical analysis.

In the group with scholastic and behavior difficulties the hostility seen takes the form of aggressiveness against others only in a few, but consists mostly of being a nuisance, clowning, calling attention to oneself in other ways, failing to cooperate, and so on.

The outstanding characteristic of the whole group of children presenting school problems is, of course, the specific school disability present in such a large segment of it. We have come to look at it as an organic problem. This opinion is shared by others but not by everybody. By "organic" we do not necessarily mean structural. The following characteristics, many of which

appear in most children, have convinced me of the existence of a well-demarcated syndrome. The child is usually immature for his age. He tends to be hyperactive and impulsive. He has difficulties in memorizing and retaining. He does poorest in subjects requiring abstract thinking and prefers concrete occupations. His scholastic performance is inconsistent and unpredictable. He shows evidence of impaired visual-motor skill. A surprising number cannot learn to spell such words as "been." He is often called "lazy."

Among the twenty-four without behavior difficulties, nineteen had school disabilities; in the sixteen with bad class-room behavior, ten had specific school disabilities. There were a few children in both groups with other organic conditions.

The conclusions we may draw from this group are much the same as those from the first group. The behavior difficulties encountered, also of an acting-out nature, cannot really be equated with the hostility seen in adults. Most of these children had biologic or environmental problems or both.

Let us now turn to the third and last group of children, the group in which the primary complaint is with some aspect of self, manifesting itself in feelings, bodily functioning, or in dealing with others. This group consists of forty-four children. They were brought with such complaints as unhappiness, with threats or attempts at suicide; overt anxiety, with such symptoms as timidity, shyness, separation fears, and other fears; somatic manifestations such as abdominal pains, cough, headache or other conversion symptoms; sexual difficulties, such as frank homosexuality, or preferences for the dress and ways of the opposite sex. Some were

brought because they could not make friends and one child because of stealing and lying. There were also such difficulties as stuttering and enuresis.

In general, it is in this group that adult-like hostility is beginning to appear, though not very much. Three of the children had suicidal thoughts; one of these was also aggressive toward other children. Two had somewhat more hostility to a sibling than is usually seen, and in the case of one of the children it was also directed against the father. It was more expressed than actualized. Similarly perhaps with two others. In the case of one child with petit-mal episodes there was fear of killing his alcoholic mother and a wish to see a psychiatrist after it was once suggested to him.

Among these forty-four children there were six with specific school disabilities, two with brain pathology, one with childhood schizophrenia, and six were mentally retarded.

What general conclusions can we draw from the examination of these hundred children that can shed some light on our discussion?

One, that these children do not represent the childhoods of the patients we generally see in our offices for neurotic problems. Pediatric psychiatry is not a "junior" adult psychiatry. The failure to see this may partly explain why so many psychiatrists do not go on with child psychiatry. Wrong theory leads to frustration. More in agreement with the facts is that these children were sorted out early because of biologic, maturational, and organic difficulties, or extremely unfavorable early environments, or both. It is important to keep in mind that the biologic and environmental may represent the same factor in some of these children. We do not know for certain that the factor in one

or both parents which led to the broken or unhappy home may not be the same behavioral factor in the child, manifesting itself differently.

Two, for an individual to develop a neurotic symptom like hostility, the original endowment of the child must be sufficiently good and the environmental influences not too traumatic, to allow for some identification with significant adults to take place and some sense of self to develop. Then the further interactions between the child and the environment will determine whether healthy or neurotic growth will take place and, with the latter, possible hostility.

Some corroboration for these conclusions may be had by the retrospective examination of the childhoods of adult neurotic patients. It has been my clinical impression that these adults as children were "good" children. I have tried to confirm this in the case of thirty-five consecutive patients. In general, these patients had been good children, often compliant. Of course many of them had problems, but they gave no "trouble."

## CLARA THOMPSON

Aggression, anger, rage, hate, and hostility are all too frequently lumped together in psychoanalytic thinking as expressions of the death instinct. If we examine these five states individually, it becomes apparent that each has its specific role in normal life. Aggression is not necessarily destructive at all. It springs from an innate tendency to grow and master life, which seems to be characteristic of all living matter. Only when this life force is obstructed in its development do ingredients of anger, rage, or hate become connected with

They were not hostile, with the exception perhaps of one. But as adults overt hostility was marked in eight of them.

Among these eight patients there were three with severe anxiety as children. Two had difficulty in going to school, but went anyway, and the third was so bright that he could take in stride missing school for periods of time. All three have led constricted lives because of their continued anxiety. Two have become exceedingly hostile individuals and the third could for a time mask his hostility in intellectual arrogance, but subsequently developed a psychotic-like episode from which he recovered. These three cases show clearly a behavior different from the acting-out seen especially in our first group of cases. Their original biologic endowment was sufficiently good and there were enough favorable influences in their environment for some growth to take place. But with continued anxiety there set in a general constriction, frustration, helplessness, further neurotic development, and the growth of hostility.

it and, eventually, ruthless aggression.

Even anger, rage, and hate have their legitimate role in human behavior in response to adequate external annoyance. If a man hits you or attacks your character, anger is the normal reaction. If he is bigger and more powerful than you, a feeling of helplessness may step up the anger to legitimate rage, and, if the facts convince you that he deliberately intended to do you harm, you would be neurotic if you did not hate him. If one lives constantly in an unfriendly environment, as in the case of

the American Negro, it is normal to show a chronic hostility toward one's persecutors. These, I believe, cannot be considered destructive drives; they are a part of man's expression of his right and wish to live.

However, all of these emotions can become expressions of irrational or pathological attitudes and it is this aspect which is the concern of the psychoanalyst. When the degree of expression of anger, rage, hate, or hostility is out of all proportion to the apparent immediate inciting cause, we are dealing with something which goes beyond immediate self-preservation; in fact, it is often self-destructive. However, even irrational behavior usually has an understandable beginning.

Just as normal hostility has its origin in justifiable fear of real danger, irrational hostility has its origin in anxiety. As Horney has pointed out, anxiety is often coped with by hostility, but the hostility, by creating difficulties in relationships, produces new anxiety, so that there is an ever-increasing burden of anxiety and hostility. Anxiety, according to Sullivan, is entirely the result of interpersonal difficulties and is originally the expression of fear of loss of approval of the mothering one on whom one's sense of well-being depends. It says, in effect, there is something unacceptable about me which threatens to ostracize me from others. The reaction of the child to this threat is to try to deny the objectionable quality, either by labeling it bad, and thus siding with the parents, or by denying it as a part of himself—that is, blotting it out of awareness. Anything which threatens to bring it into awareness produces anxiety and there is a tendency to be hostile toward the external influence. For example, a woman who always had difficulty in saying "No" to

a sexual overture and who, at the same time, still had the puritanical standards of her childhood background, would invariably become hostile to the approaching male whom she had unwittingly encouraged. In other words, irrational hostility appears when some external influence threatens to make one aware of dissociated impulses in the self, impulses which at some time threatened one with losing the love of a significant person upon whom one was dependent.

Overt irrational hostility appears most often when threatened by one of two situations. As already mentioned, when the defense system is challenged and threatens to give way, making unacceptable aspects of the self conscious as in the case just described, there is a reaction of anger against the force which is threatening the exposure. The other situation is a special case of the above and is, I think, a defense against despair. Sullivan has called it the malevolent transformation of the personality. When, in the course of seeking tenderness the child habitually receives instead a rebuff, he comes in time to equate all longings for intimacy and tenderness with danger. Accordingly, he reacts with hostility to all friendly approaches. Thus, during a long analysis, I struggled with a patient, who, whenever he found himself feeling a little friendly, would invariably attack me with some sarcastic reference to my inadequacies. He was married to a woman with whom he lived in constant turmoil—if one were to accept his daily reports at face value. Yet he had never been interested in any other woman and it was obvious from his behavior that he treasured her shortcomings, not as a reason for leaving her, but as a reason for feeling safe with her.

Of course, the hostility which one

encounters in therapy is not always as open as this. I think of a woman whose father had loved her, but had been sufficiently afraid of his wife so that he could not protect the child from the mother's onslaughts. On the surface, the patient identified me with the loving father, but she also feared that I was weak like him. This she didn't mention, but secretly she collected adverse criticisms about me and often made rather disparaging remarks to others about me. She did not tell me any of this until one day when one of her remarks about me to a person unfriendly to me placed me in a very embarrassing situation and brought her pattern of acting out to my attention. Obviously, her hostility to me grew out of anxiety that I, like her father, would one day throw her to the wolves, so she put me to the crucial test, all the time consciously believing she had great confidence in me. These hidden patterns of hostility can be assumed to exist in all defensive character patterns, for the defensive character trait was formed in the first place to cope with anxiety. Even the most meek, submissive patient will manage in some indirect way to be hostile. This has to become clear to the patient at some time during his analysis if there is to be a successful resolution of his difficulties.

Some analysts seem to feel that, since hostility is always present, time would be saved if the analyst sets up a situation calculated to make the patient angry. This was done quite extensively in the 1920's, but I think it does not accomplish its purpose because, for one thing, it gives the patient legitimate cause for anger, which is not necessarily the repressed hostility. My second objection is that it is contrived and is, therefore, not sincere. I believe thera-

peutic results are achieved only through genuine interaction of analyst and patient. No analyst enjoys a hostile attack unless he is a sado-masochist, but it is essential that he be able to accept it without feeling his security is threatened. By this, I do not mean that he brush it off as if he were impervious, but that he recognize it as an attack, while concerning himself with helping the patient to discover the cause of his great insecurity at that moment. If the analyst, being only human, has actually unwittingly done something to precipitate the outburst, he should acknowledge his part in it.

Can one cope with all forms of hostility in patients? The answer is "No." If the patient, from the first hour, has a strong dislike for the analyst, I think it does not promise a good therapeutic outcome. It may mean the patient is too sick to trust anybody, but it may mean that some particular characteristics of this analyst are, in reality, too much like something in hated authority figures of the past. Coping with this will be a great burden for both analyst and patient. Usually, the patient solves this by leaving after the first interview, but sometimes one encounters a person who has learned to love a hostile situation. Then the analyst must beware of any tendency on his part to masochistic submission.

I once had a patient who had driven her previous therapist to the point of throwing her out by attempting pseudo-suicidal tricks in his office. Secure in the realization that she could make him feel guilty, she kept it up until in a rage he got rid of her. As a part of my definition of terms for accepting her for treatment, I stated that the first time she attempted anything like that with me treatment would stop. Analy-

sis was not a bed of roses, but, at least, the only dramatics she ever attempted was once throwing an ash tray across the room, and I seem to have done her some good in the course of a few years. The point I think I am making is: do not try to deal with an initial hostility by the kid-glove method. You won't be able to keep it up and the patient will exploit it. You must decide whether you can stand this person's particular brand of hostility or not. If you can, you can probably help him, but if you can't, don't try to treat him. The result will be either open disaster or a hostile symbiosis which gets nowhere in the end. On the other hand, concealed hostility often appears as a powerful manipulative "positive" transference. The patient falls in love on the spot and he believes no one else can understand him or her. This points to two things, an infantile type of dependency, expressing great helplessness, and a compensatory resentment that all these dependency needs are not met. In the course of cure, this type of patient usually becomes very hostile.

I suppose I have been invited to participate in this discussion partly in order to state any deviation in my thinking from Horney's on the question of hostility. As to its origins, I find we are less in agreement than I thought.

I see its origin always in early anxiety situations. According to the discussions of this panel, Horney stressed rather the hostility growing out of the neurotic defenses and their frustration. This is certainly one source of hostile development, but, I think, earlier origins should also be stressed, as I have tried to do. Also, it is my impression from her writings and from my own work with her that she tended to place more emphasis in therapy on the patient's hostile reactions as such than I do. I do not find it valuable in my work to deal directly with hostility unless it is so overwhelming that it must be handled. I prefer to explore the underlying anxiety for which it is a substitute. In this way, its dynamic roots become apparent and the hostility tends to fall away of itself. In my experience, a patient who is seriously undertaking therapy is much more eager to cooperate than to fight except at moments of great insecurity. If the relationship to the therapist is one of basic confidence and the therapist has a genuine feeling of acceptance of the patient, the moments of hostility are fleeting and usually lead to new insight. In other words, whenever the patient is hostile without provocation from the therapist, it is a signal that an anxiety area has been touched upon, and investigation of that area is the important job.

#### LOUIS LANDMAN

The subject for tonight's panel is a provocative one, but difficult to approach in a definitive manner. When I first thought about hostility and went to the dictionaries and the literature for definitions, I found myself at a loss.

There didn't seem to be clear distinctions among the meanings and usages that would differentiate the various categories of hard feelings and acts: hostility, aggressiveness, sadism, vindictiveness, rage, revenge, hate, coercive-

ness. Meanings and usage often overlapped, and to add to the confusion the terms were used to describe both the feelings and the action taken on the basis of the feeling.

I was amused one day to read that the United Nations had similar difficulties and had abandoned its ten-year search for a definition of aggression.

While I was puzzling to find for my own clarification a meaning for hostility that would differentiate it from the other terms, I was helped in my thinking by the distinction made in the literature by Frank Brodman,<sup>1</sup> who said: "Aggression is the expression by word or set of a feeling of hostility." I was reminded of a compulsive, assaultive patient who said, in a reflective mood, "Anger takes so many forms with me." That rang a bell for me. This patient had just emerged from a lengthy siege in which she had run the whole gamut of the hard feelings and actions several times over, touching on all the variations and combinations, including, but not restricted to, vindictiveness, self-hate, rage, vengefulness, coerciveness, destructiveness, physical assault, and after a period of reflectiveness, which I was pleased and relieved to see, healthy assertiveness.

The hard feelings were directed primarily against herself, her husband, her daughter, and last but not least, me. Her self-hate was the result of an awareness that she was not living up to various aspects of her idealized image as the perfect woman, wife, mother, and analysand. Her vindictiveness, vengefulness, coerciveness, rage, and physical violence were directed against her husband because he did not live up to her picture of him as the perfect man, husband and father, and because of her externalizations onto him, and to coerce him into becoming his idealized

image and into helping her become her own idealized image. Her rage against her daughter was in part jealousy, in part externalized anger, and in part an assault on the daughter in an attempt to coerce her husband. Her hostile feelings against me were very great. She avoided them as long as she could and they were, in part, the result of my not satisfying her demands for unconditional love, and because the analyst had intruded into her neurotic structure and was undermining her defenses.

After the storm abated and the dust had settled, she was able to say that she finally saw that it was necessary for her to take certain steps in her own behalf—and she did take them. In large part, this storm of anger was for the purpose of protecting a masochistic pattern, and to prevent this awareness from emerging.

This function of the hard, angry feelings has been described by Karen Horney<sup>2</sup> and others who saw it as a method of defending the status quo of the neurotic defensive system.

This example helped clarify my thinking and I saw that it is possible for me to think of hostility as the hard, angry feeling, and aggressiveness, vindictiveness and coerciveness as the action taken on the basis of these feelings. With this formulation I felt relatively comfortable. It appeared to fit in with the theory of neurosis as described by Karen Horney. As she described it, the neurosis is a system of defenses, unconsciously devised by the insecure, frightened person to protect him from a world which he experiences as threatening. The neurotic invests his defenses with pride, and when these defenses are threatened, anxiety is aroused, hostile feelings are experienced, and aggressive actions are taken to drive the intruder back and maintain the solidarity of the

defenses and his security behind them.

A patient seemed to describe this when she said, "All weekend I've been cherishing my anger toward you. I could feel this rage coming on. I was annoyed when you said 'such and such.' This same patient, talking about a big argument with her brother, said, 'He started a barricade of insults.'"

It would appear that the more important the defensive position, the greater stores of hostility that are available for its defense.

The neurotic defensive system may be threatened from three directions: from without in interpersonal relations, from within by intrapsychic activity, and by the analysis which exposes the neurotic system to examination, evaluation, and change.

In interpersonal relations, these defenses may be subjected to pressure and trauma at any time. The innocent bystander may have no way of recognizing the defenses until after he has inadvertently intruded into them and received a defensive blast of aggressive activity to drive him back. One potent source of such hostility emanates from the theoretical concept which Karen Horney called the Idealized Image. According to her thinking, the neurotic, in an attempt to reconcile the contradictory major solutions and eliminate conflict among them, retreats into imagination where he tries to fuse them into one figure. In the idealized image contradictory trends are exalted as different facets of a rich personality. When, as must inevitably happen in his interpersonal relations, other people do not give evidence of any recognition of his self-given qualities, he will be assailed with doubt and anxiety. If, indeed, other people openly ignore these qualities, the image will feel seriously threatened. To reassure himself

of the validity of the image he has created, he must have constant evidence from others. In an attempt to have other people recognize, accept, and accede to the image he has created, he makes claims on the basis of unilateral bargains. As a result he endows himself with rights and privileges and makes demands on other people. When the unilateral bargain is not acceded to and he does not receive the special consideration, deference, and attention he feels entitled to, he experiences hostile feelings. He may feel justified to react with vindictiveness, and punish and even seek revenge for the injustice he has experienced, and to coerce the other person to retract and make amends for this imagined injustice.

This sequence may be interrupted and repressed at any stage. He may not be aware of his hostility, but may repress it, or turn it inwards against himself. Or he may be aware of the hostility, but suppress any vindictive action, or turn against a more available object outside, or against himself.

The neurotic structure is threatened from within as the real self attempts to emerge and as the individual becomes increasingly aware of his own feelings, desires, and yearnings. Karen Horney has described this as central conflict: the conflict between the real self and the pride system. As the individual gains in strength and assurance he recognizes the fallacy of his neurotic mechanisms and makes attempts to move away from them and recognize and act on the basis of spontaneous, healthy desires and feelings. At this point enormous hostility may be mobilized against the emerging, constructive forces and unconscious action taken to drive them back, nullify them, and reestablish the neurotic mechanisms. Clinically, this may be

seen as a recrudescence and exaggeration of self-doubt, self-hate, disturbed interpersonal relations, anger toward analysis, and attempts to discontinue the analysis. If this storm is weathered and the healthy move is made, it may be followed by a second wave of hostility, as if in punishment for the move and as a warning not to attempt another. An example is a detached patient who complained bitterly of loneliness. He had slowly begun to emerge from his isolation and establish relationships. Recently there had been an extended stormy period during which he repeated and relived attitudes I thought had been worked through. Then he quite suddenly decided to give a party in his apartment, the first he had ever given. During the session following the party, he described in detail and with obvious enjoyment his preparation and efforts to make it a success. It was an eminently successful party and he met and made progress with an attractive girl, but, unaccountably toward the end of the evening, he became depressed, drank heavily, and stayed out of the activity. The next day, while on a subway platform, he suddenly was overwhelmed with a desire to kill himself and had to hold onto a post with both hands to keep from throwing himself in front of a train.

Another patient, with a fear of her own sexuality and her sexual desires, repressed them and protected her repression with a complicated system which included pride in independence. At the same time she denied her part in this neurotic defense by blaming her husband. He was impotent, not sexually attractive, etc. Finally one day she said, "If I needed a man for sexual gratification, I would be dependent. I wouldn't be independent." To maintain this independence she was hostile

toward him before and after intercourse, which contributed to his impotence and premature ejaculation. The result of this complicated maneuvering was to blame him for her not having sexual feelings. Shortly after this came to light, for many reasons, she was able to allow sexual feelings to come to the surface freely and to have intercourse successfully.

The defensive functions of hostility frequently appear in the patient's relations with the analyst. The patient comes for help because of the pain and suffering he experiences as the result of his neurotic defenses. His compliant attitudes have resulted in a blunting of his growth and assertiveness. He is misused and exploited by more aggressive people. The expansive person, in his attempts to conquer life has rejected the feeling, warm part of himself. He has provoked resentment and retaliation from others as a result. The resigned person is alienated from himself, from living, and from others. However, this does not mean that the patient sees the inadvisability of his defenses and wants to tear them down. In many instances, it means that he is unhappy about the disadvantages of his defensive structure and wants the analyst to do something about that. What can be done, or how it can be done, is immaterial to him—the compliant person trusts the analyst to do it, the aggressive person demands it. He wants the analyst to help him make his defenses more effective, and without disadvantage to him. When the analyst, instead of going along with this idea, attempts to understand the patient and investigate his defenses from the ground up, the patient becomes resentful, suspicious, and hostile. And understandably so, for as he experiences it, his security in this hostile world results

from his defenses. He has little faith in his own resources—and less trust in the outside world, including the analyst. And so he is hostile and moves to defend with rage, vindictiveness, and aggressiveness.

Other attitudes are present, or else the analysis would never proceed beyond this point. The patient trusts and works with the analyst for rational and irrational reasons. He takes courage and gains in confidence as the analyst firmly proceeds with the work at hand. He gains confidence when he feels that the analyst does not wish to deny him his defenses, which he still needs.

For a long time the patient cannot accept his hostility to the analyst and does not experience it as such. The compliant person feels that hostility is an unseemly emotion to have at any time, and especially toward a doctor who is helping him. The expansive person fears retaliation if he should express hostility, and the resigned person does not want the even, placid calm of his living ruffled by any unpleasant emotion. However, since the analysis is intruding into their defenses and they are becoming aware of attitudes and emotions that they had long since believed were buried without a trace, large amounts of hostility are generated. Since they do not allow themselves to experience their hostility and cannot express it directly, they do what is available to them. They may externalize it and feel that the analyst is angry with them, for whatever reason, or that the analyst doesn't like them because of whatever reason, or that the analyst doesn't understand them, or approve of them, or give them credit. Or they may project their hostility—their father is opposed to analysis, or their girl friend is, or the church is, or some doctor is, or some cartoonist in

*The New Yorker* magazine is. Or they may act out their hostility by coming late, upsetting ash trays, inciting their father to rant against analysts and order them to stop analysis.

One man I worked with came to his initial appointment, literally, with his wife leading him by the hand. His eyes were small, half-closed, and downcast. My first impression was that he was blind and I was startled when he released his wife's hand and walked by himself into the office. After he started therapy, it became clear that a primary line of defense for him was not seeing, not noticing, and hiding in the dark. This he acted out with behavioral and sexual disorders which I won't describe. Analysis, with its implications of seeing, bringing to light, and opening up, was a threat. He reacted by being late, habitually and excessively. Months later he said, "People are noticing that my eyes are bigger than before." He began to look at people and looked them in the eyes. He was surprised that they looked harmless; they didn't look like the monsters he had imagined them to be.

It is only later that patients begin to develop some feeling for themselves and some respect for their own fears and hostilities. When they also develop confidence in the analytic process they are able to take their externalizations back into themselves and face and experience their hostilities to the analyst.

However, this hostility is a potent force to be respected. One patient said, "I don't want to admit that I'm coming here, that I'm under analysis, because that would mean I am sick. I dread that. I don't want to admit anything that makes me uncomfortable. I deny it. I use any excuse. For me to tell you anything is wrong is terrible. I don't want to admit I have any conflict. I'd

like to think I'm well, strong, well-adjusted. I have all these problems and I won't admit it. One of the hardest things I have to face is that I am sick." And so on. . . .

His hostility was enormous. Earlier he told me that he had bought a switch-blade knife and carried it to my office for six months. If I had said the wrong thing he would have used it on me. He didn't know what the wrong word was, or what it could have been, but he was prepared for it. During this period, he had told me he was afraid of his angers. A friend had made some remark and he went wild with rage and picked him up and would have thrown him out the window.

A young woman patient wanted me to treat her like a lover. I was expected to be kindly, affectionate, and tell her everything was all right, that there wasn't anything wrong with her, that I would take care of everything, that I would treat her for nothing, that I would be her devoted slave. Instead of that, I asked her questions, I pointed things out to her, and I expected her to pay for her analysis. In a burst of rage she said she'd like to kill me, break every one of my bones, crush my skull, and cut me to pieces.

That the patient can allow herself to bring hostility out into the open and experience it is an encouraging sign and is evidence of increased confidence in herself and in the analytic process. However, it is not an end in itself, although it may be the beginning of an end. When she can make the connection between her hostility and the defensive position that is being threatened, and then feel strong enough to relinquish the defensive position as no longer necessary, then something im-

portant has been accomplished. After this point, the hostility diminishes because it no longer has a purpose.

While the defensive or reactive value of the feeling of hostility seems clear to me at this time, I do not wish to imply that all hostility is neurotic. The individual bent on growing and expanding will experience hostile feelings when his activities and desires are unfairly interfered with or frustrated. What action he takes to deal with, eliminate, or accept the frustrating element depends on the relative health of his emotional structure and the severity of the situation he is in. The father whose adolescent son is questioning his authority and threatening his position as the dominant male in the family will undoubtedly experience hostility toward the threatening son. But if he is secure and healthy enough, he will understand his hostility and accept his son's growth and independence.

It is the insecure, frightened father, or the frustrated, defeated male who never accepted his own masculinity who will be excessively hostile toward his son's striving for fulfillment, and will attempt to frustrate him or castrate him. And it is in the jungle atmosphere of the neurotic family constellation where the vengeful son waits for the opportunity to overthrow the repressive, authoritarian father because only then can he assume his own authority. In this jungle atmosphere the father defends his authoritarian position with hostility and violence.

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## JOOST A. M. MEERLOO

When I received the invitation confirming that I was to take part in this panel on hostility, I felt rather puzzled. The secretary had enclosed a definition for the guests of the panel to elaborate on: "Karen Horney conceived of hostility not as an innate primary process, but as arising secondarily from frustrated wishes or claims."

Was this definition meant as a limitation or as a challenge to act out my own pleasure in argument?

But then I realized that the very word hostile is related to *hostilitas* and *host*—enemy and friend—and has deep ambivalent roots. Because you are my host I have to forsake my hostility.

Yet as a clinician I always feel at a loss with a single generalizing theory. So much depends on the semantic use of the words hostility, aggression, rage, hatred, and even the word frustration. So let us tentatively define aggression as the normal tool of self-assertive defense, and hostility as the anticipation of such a defense with all its fantasied implications.

The act of being born is in itself experienced as a hostile exposure and, indeed, in many mammals the young are rejected and have to die if they are too weak to reach the mother's nipples in a certain time. This rejection of the weak, however, is a meaningful self-defense of the flock lest the weak prevent the herd from its "trek" and expose themselves and the flock too much to the enemy—the animals which prey upon the weak.

With this biological example we are in the midst of the paradox about hostility and defense, for often hate and hostility act as tension-reducing devices.

That is why I want to talk most about the human paradox that both hostility and love can be a mask and a defense.

I have in mind a man with whom I have been struggling for years in order to understand his hostility better. By his boss and his ex-wife he is called the most hostile man that exists in the world and, really, his hostility has jeopardized every means of his existence. Only after years of treatment do we together understand that behind the mask of hostility lives the most sensitive little boy who even at this very moment needs to make use of his snappy, aggressive behavior as a practical defense in order not to be overwhelmed by the world. He needs his hostility as a device for living, as a pseudo-ego, his only pride.

True, some clinicians call such a case a borderline schizophrenia, others ultra-masochism. But when we ask what is at the root of his hostility, different students will give various answers depending on their particular viewpoint and field of interest. The biologist will say: his lack of tolerance toward any stress is the result of hereditary structural anomalies. In animals we can study this relation between tolerance-capacity and hostility and aggression very well. In the epileptic fury—the worst clinical form of destructive hostility we know—man exhibits not merely a reaction to frustration but also suffers from an organic mismanagement of energy. Freud's concept of *destrudo* is somehow related to this anti-vitality principle and mismanagement of energy.

The orally oriented therapist will say: see, this hostility is not real aggression, but a masochistic defense against oral incorporation.

The merely anally oriented analyst will show us in this case the warding off of primary parental persecution with anal magic and defiance.

Those who stick to the primacy of the Oedipus complex will explain that beyond all this patient is still symbolically killing his father and every comparable authority, his ex-wife included. Or they explain his aggression as a reaction-formation against his castration fear. Sometimes aggression replaces pure libido; sometimes it is the opprobrium of it.

The more environmentally oriented student of social relations will give me insight into the manifold frustrations the man went through, inciting a vicious circle of new frustrations.

The existentialist among us will say in philosophical terms that we hate what we depend on, and the more we depend, the more we hate. Man's hostility is the guilt of existing, his creativity the eternal rebellion against his creator.

The over-moralizing therapist will philosophize about hatred, hostility, and original sin, and will emphasize that the child has to learn to love those who frustrate him.

Those convinced of the conditioning effect of early infantile traumata will formulate that every hatred and hostility is primarily hating something in oneself; it is an abstract hatred directed toward the early magic introject.

Those who prefer to analyze the defense mechanisms as a therapeutic device see hostility as a frustration and disguise of infantile megalomania or as a pseudo-aggression covering up deeper-seated guilt and self-destructivity. Others may talk about primary and secondary aggression, and we are all aware that man becomes enraged when

he sees qualities in others he does not like in himself.

These are all metaphors, sometimes giving clarification, sometimes obscuring the individual peculiarities of each case. Sometimes "non-cooperative non-aggression," like the strategy of *satyagraha* in India, can be experienced by the other party as more hostile and haughty than the destructive fury of a shooting enemy. The Nazis in the concentration camp had a special expression for this; they called the poker-faced control of hostility "physiognomic insubordination." They were afraid of it and punished it more heavily. They only tolerated meek faces.

Why this diatribe?

Because I don't believe in a delimiting definition and a single simple theory of hostility and aggression. Spinoza said: "*Omne determinatio est negatio.*" Any definition is a limitation. We always have to take into account many factors, biological and energetic factors included. Sometimes there is an overflow of energy, sometimes a lack of energy that may let us act with hostility.

But the most important of all is that hostility, as we use it semantically, is the expression of a complicated human relationship. It often depends on what the mate, or the environment, or the culture is used to accepting as hostile. When a child doesn't get affection it prefers hostility as a paradoxical tie. It is also strangeness and the unknown that may make us feel hostile.

Everywhere the initial struggle for dominance and submission between man and his brother-man is solved in different ways. This is the horizontal relationship between fellow men. Self-assertion and rebellion constitute (or did) a Western ideal but are looked upon as hostile in Eastern culture.

Yet, hostility is also determined by

hidden vertical relationships in which the person on different levels of his psyche reacts differently and in which one part in him may act hostile and destructive toward the other part as, for instance, in psychosomatic diseases. A hostile threat is mostly more a symbolic trigger than a reality danger. We see this especially in the sexual act where taboo and non-understood guilt come into play—and may convert bodily pleasure into feelings of hostility.

To close my paradoxical contribution as a non-hostile guest of my host, I want to tell you of a so-called peaceful, harmonious couple both of whom were active in the pacifistic movement. Both were ardent students of psychology and both were always holding hands and trembling when the words hostility and aggression were heard. She, however, was the dominant idealist.

The marriage went on the rocks when she discovered that he had an additional homosexual marriage. Their harmony proved to have been fraudulent. Their mutual love had been a mask. Their sexual encounters had been an unconscious attempt at mutual destruction. By the way, there is in our disturbed epoch much more fornication out of hostility than out of love.

It was this tragic case that taught me the paradoxical meaning of harmony and hostility and the many angles of the

problem of hostility and aggression.

Finally, I want to say something about the inadvertent hostility comprised in an elaborate panel discussion as organized today.

What sounds seemingly democratic—to hear contrasting opinions—actually results in minimal rapport and transference. The audience looking at the reading “skulls” hidden behind desk and microphone is forced to swallow a maximum of sophistication. Remarkably few speakers can be found who will talk freely without recourse to a prefabricated paper.

In our technical age there is a general uneasiness about rapport and listening quietly to one man or woman and using the transference as learning experience.

This mutual suspicion and distrust disguised by so-called scientific democracy is nevertheless one of the causes of the many schisms in our profession. Our panel-paranoia is only part of this hidden hostility and suspicion among people, as we find it even more elaborately in the confusing huge textbooks written by many different experts.

In conclusion, there is something in hostility—and the freedom to express it—that symbolizes part of man's self-reliance and self-confidence, because there is no fear of retaliation and no uneasiness about aggressive discussion.

#### BELLA S. VAN BARK

Tonight's subject represents one of the most complex, poorly understood, and puzzling problems in the lives of individuals in society and in psychoanalytic theory and therapy. The forces promoting, exaggerating, and perpetuating hostility are multi-faceted and in-

terrelated. In our psychoanalytic thinking there exists a pervasive tendency to refer to hostility in an undifferentiated way, so that the term has become a catch-all, similar to for instance “psychopathic personality.”

In my discussion I shall use the term

hostility to refer to the reactive components which are the dynamic forces promoting, or potentially promoting, reactive-destructive acts of many kinds. I shall use the term aggression to refer to the reactive-aggressive acts promoted by hostility which may or may not have the intent of harm to self or to others.

All human beings have the potential for fear, anger, rage, and intense fury. In the course of living, all individuals at one time or other encounter unbearable, painful, and dangerous situations which can, to a large degree, be guided toward alleviation or elimination. Unfair attack, unjust derogation and disparagement, deprivation and neglect are fairly common experiences. We also meet life situations we cannot handle. To the extent that an individual is aware of his genuine feelings, wishes, fears, thoughts, and beliefs, and is in command of his imagination, he can sensitively and accurately perceive the nature of the situation and decide on the action most appropriate and suitable for a creative solution. In this ideal state of being, an individual has achieved a rationality of thought as well as a rationality of emotion. In a recent article, John MacMurray<sup>1</sup> presents some stimulating thoughts on the theme of "Developing Emotions," which are very pertinent to this discussion. In short, the relatively healthy individual has his feelings, wishes, fears, and beliefs in hand and proceeds to fight constructively toward the aims he has in mind—specifically, toward an increasing self-realization, in whatever degree possible. He is activated, or his actions are grounded in growth, knowing when he ought to fight and when he wishes to fight.

As psychoanalysts we are faced with the task of exploring and exposing all the forces which distort an individual's

accurate perception of himself, of others, and of the true nature of a challenging situation. We must also interest ourselves in therapy in directing the patient toward investigating and experiencing the forces which distort his awareness of his feelings, thought, fears, and beliefs, and impair the spontaneous flow of emotion and thought. These forces, powerful and pervasive, affect the whole personality of the individual and promote reactive anxieties, hostilities, and aggressions. Interferences with the process of personality growth produce excessive emotional responses and impaired thinking, leading to actions harmful to the individual or to others.

In the references to hostility, frustration is stressed as one of the major experiences productive of hostility in an individual's early and later life. This does not take into consideration the additional influences in the external environment that affect—and continue to affect—the infant, the young child, and the adult. In large measure, frustration plays a major role. What is needed is a clearer delineation of the nature of the frustrating influences, of what is frustrated in the growing organism, and the consequences of such frustration. Although Leon Saul<sup>2</sup> does state that the tendency to aggression, which he labels hostility, is not inherited per se, he regards hostility as a biological mechanism of adaptation which has overshot itself, and raises the question of the reason for its continued existence with such force. He finds the source of hostility in disorders of adjustment in childhood. At this period, the outcome of hostility is determined not only by the intensity of the hostility created, but by the ways in which it is handled. He believes the individual can permit, control, and transform hostility. Hostility can then

be expressed in an antisocial, anti-personal, or social way. What Saul refers to as sources within the person from which hostility is generated covers a small part of the vast terrain from which the forces promoting hostility can be drained. He insists that the growing organism, whose normal, healthy growth is not interfered with, develops only social, friendly cooperation—that is, he can direct his hostilities or sublimate them toward socially constructive ends. Such thinking reflects some adherence to the Freudian postulate of a death instinct, with destructiveness toward self or others as its derivation.

John Paul Scott<sup>3</sup> concludes that no evidence points to the existence of any innate desire or need to fight which individuals have to satisfy for their well-being. On the other hand, he emphasizes that individuals need to acquire some suitable and satisfactory outlet for their aggressions to sustain their vitality. Scott suggests that training in the passive inhibition of aggression may help in dealing with aggressions. He attributes all provocations to fighting to external stimulation and points to the necessity for change in environmental factors as another approach to the problem of fighting in general, a field which requires investigation.

Fear and anger are basic human emotions which are essential to dealing with dangerous or potentially dangerous situations. The capacity to feel and to admit fear and anger—as well as the capacity to fight—are essential to an affirmative personality. John Steinbeck has written, "Any man who isn't angry at one time or another is a waste of time. Anger is a symbol of thought, evaluation and reaction; without it what have we got? I am tired of non-angry people. I think anger is the

healthiest thing in the world." To return to the hypothesis that frustration is the major source of fear, anger, and rage; a few words about the infant. Frustrations inevitably will occur and some are necessary for all growing organisms. When these frustrations are in a spirit of warmth and good will, when they permit a clash of wills and wishes and allow for friction in the context of an appreciation of the natural rhythm and individuality of the growing organism, relatively small impairment of spontaneous growth will occur. In infancy and in the early years, attention must be given to the particularly strong needs of the growing organism to have satisfactory experiences in dependency, periods of aloneness and togetherness, and opportunities to make contact with the world through his senses. Abrupt interferences of all kinds, undue pressures and irritations in the nurturing adults, too much or too little togetherness, or apartness in a tense, cold, frictional environment are some of the traumatic forces that engender fear, anger, and rage. During toilet training and the period when the young child is beginning to try his will and familiarize himself with his environment, a number of experiences—among them excessive cautioning, contention, confusion, direct threats, open hostility in the environment—can contribute to the formation of fear, apprehension, and a sense of potential or actual danger from without. Along with this perception, the young child must do something with his own feelings, fears, wishes, and impulses. If the environment permits the expression of fears, angers, and wishes and shows warm, adequate, respectful appreciation for the young individual in his predicament, the child can at least develop a respect for his core of human-

ness. When such responses are unavailable and the child has no opportunity for developing his feelings, thoughts, perceptions, and wishes, he may begin to distrust the validity of them. Continuous experiences which impair the child's impulses toward strengthening and clarifying his perceptions, emotions, wishes, fears, and thoughts inevitably affect his capacity to express himself and to fight for himself. Even though a child may become pugnacious, this pugnaciousness is itself rooted in fear and apprehension, distrust, and anxiety. Horney<sup>4</sup> states that "... the conflict between the individual desires of the child and the environmental requirements may lead to factual restrictions and suffering." When this conflict occurs in the ideal atmosphere little, if any, neurotic anxiety is generated. Dollard<sup>5</sup> refers to the anger-anxiety conflict generated and originating in infancy and the early years. In the views of some analysts, this conflict between infantile desires and the environment becomes the inner source of the adult conflicts with authority figures and contributes to later hostilities. Horney has shown that only when this conflict generates anxiety and when the attempts to allay anxiety lead to defensive tendencies which are imperative, yet incompatible, does neurosis begin. It would seem that fear, anger, and rage which are met with inimical and hostile responses in the environment increase the growing organism's apprehensiveness and provoke anxiety.

Basic anxiety has been defined by Horney as feeling isolated, helpless, and weak in a potentially hostile world. She states that basic anxiety is interwoven with basic hostility. I would add to this distrust of self, fear of one's own fears, angers, and rages, and disturbance and rejection of one's own feel-

ings, rhythms, wishes, thoughts, and motor experiences and impulses.

In an atmosphere of external hostility and internal insecurity, the young child must to some extent resort to his imagination and pretend to himself that all is well, both outside and within himself. But at some level he registers that all is not well. The initial pretenses and distortions necessitated by the external environment begin to divert the direction of the child's growth. His fundamental human needs to be with others in friendliness and cooperation; to strive with others; and to increase the use of his own capacities, which necessitates fighting for himself and toward growth and to be alone with himself, remain unchanged. To the extent that the young child is pervaded with basic anxiety in an unchanged external environment, he may begin to live in terms of overemphasis on one or another component of basic anxiety, such as helplessness, hostility, isolation. As he perceives his world and himself in it as they actually are, he may suppress and repress most of his anxiety, apprehension, and hostility. I believe that even the child who is pugnacious or withdrawn is not necessarily less affected by suppressed or repressed hostility, among other repressions. No matter how deep the repression, the forces continue to influence his feelings, thoughts, and wishes. The most potent force contributing to fear of the repressed components, it seems to me, is not that they represent the "bad" aspect of the personality, but that their emergence would bring into awareness feelings of defenselessness, helplessness, and isolation in a non-responsive, distrusted environment with which the child is already unable to cope effectively.

As repression continues and diverg-

ent ways of coping with the external environment come into the picture, genuine wishes and feelings become blurred and less important. Whatever is out of awareness may register as a fearful, violent force or may produce an inner sense of corrosion—"the acids of hate, anger and even unexpressed love." When imagination enters the picture to distort, or is used to arrange, feelings, wishes, and thoughts to fit the picture of what would be safe and what would result in some personal satisfactions for the anxious individual, strength is added to the fear, angers, and rages that have been generated. Fear now becomes attached to the emergence of repressed, hidden aspects of personality which can never be developed or acknowledged. In trying to achieve a sense of wholeness and order, and to maintain some rhythm and direction in his pattern of living, the neurotic individual uses his imagination, prompted by anxiety, to distort or fabricate feelings, wishes, attributes, thoughts, and beliefs in the context of his predominant style of coping with life. Included in this style is a powerful aversion to perceiving the truth of his feelings, wishes, fears, and thoughts. Subjective values of intense importance are attached to the distorted perceptions of self, of situations and of others. Much energy, which ought to be available for constructive and creative fighting and struggling, is expended in maintaining the distorted perceptions of thought and feeling. Inherent in the neurotic superstructure are precariousness, vulnerability, hypersensitivity, and a myriad of touchy areas which, when provoked, may arouse secondary reactions of anger and rage. These secondary reactions may become a defense against awareness of a host of underlying reactions that the

neurotic individual must deny. Among these are the very fact of anger and rage, of vulnerability and fear. Some of the dire consequences of this superstructure are despair, accentuation of dependency on others for support of the distortions of self, increased distrust and fear of hostility from people, and increased anger and rage within the individual. Increased anger and rage, as they impair the capacity to fight and blur what the individual is fighting for or against, as well as what he can fight with, creates some of the apparently unprovoked aggressions. The neurotic individual can feel just as much anger, rage, and hate for himself when he perceives the discrepancies between his distorted picture of himself, as he is, and the world as it is. To simply say that we hate in others what we hate in ourselves is to oversimplify the power and the deep roots and excessive value the neurotic attaches to his distorted perceptions.

Chronic hostility can become a way of life or represent an over-all defense in depth of extraordinary tenacity, particularly in an individual who has or sees no other way of handling severe inner conflict in wishes, feelings, fears, thoughts, and beliefs. From the total neurotic structure is generated the major stream of reactive anxieties, hostilities, and aggressions. This stream is fed by the continually provoked fears, angers, and rages which are secondary to the intensity of response to whatever is conceived of as potential or actual danger to the neurotic house of cards—a house of cards which, after all, has its primary function in the maintenance of life. Outbursts of anger and rage are one of the major functions necessary to a human being. Vulnerable and easily hurt as the neurotic through his hypersensitivity may be, he not only

desperately needs, but is trying to satisfy, a social urge.

As Aristotle said, "Anybody can become angry—that is easy; but to be angry with the right person and to the right degree and at the right time and for the right purpose and in the right way—that is not within everybody's power and is not easy."

This certainly is not easy—in fact, it is almost impossible—for many of our patients who perceive the world as a jungle for which they are ill-equipped and in which they are contemptible, weak, friendless, and somehow inferior. Psychically, at every turn, there are possibilities of hurt and they themselves are the innocent victims. In therapy I have found it of value, and liberating to the patient, to interest him in the exploration of the complexity of the emotional experience he refers to as being angry, or "mad," and to help him see the connections with preceding events in the immediate situation, as well as with earlier situations. Helping the patient bring into awareness the structure of his defenses opens him up to what is behind him and strengthens him to become more fully and clearly involved in the multiple conflicting wishes, feelings, and thoughts connected with reactions of anger, rage, and hate. I feel that greater courage on the therapist's part and greater clarity in perceiving, and helping the patient to bring them into awareness in accordance with his rhythm contributes to the diminution of therapeutic impasses. There is inherent danger in the tendency to be overly reassuring to the patient when his conflicts are about to emerge. At this point the patient may show more anger, rage, and reactive aggression of various kinds. We, as therapists, must be careful not to repeat the mistakes of unwittingly supporting or

enhancing the patient's conflicting attitudes toward feeling, expressing, or acknowledging fear, hurt, anger, rage, murderous fury, wishes to clash and engage in friction, or desires to be critical or to raise objections. This means attention to the whole personality invaded by intrapsychic conflicts which may be provoked by the environment and transferred to the therapist as himself or as a figure from the past, and then reacted to as an external provocation or threat.

Removed from the limiting influence of the framework of the death instinct as the force promoting hostility and aggression, both problems are seen in a much larger perspective. This larger perspective makes for intricacies in the therapeutic process but also increases the patient's potentialities for liberation from reactive anxieties, hostilities, and aggressions, actively and passively expressed. This road is long and arduous, but one I am daily convinced is most fruitful for our major goal in therapy: to help the patient to a clarity of perception, a deepening of his feelings for and of himself and others, an increase in the capacity to establish values in accordance with his own genuinely undivided feelings, wishes, and thoughts. On the basis of such values he can then decide what he ought to fight and what he wishes to fight and what are the best means for the creative conflict in which he desires to engage. To move along such a road, the therapist as well as the patient must work toward the elimination of illusory values which produce defenses against these painful emotional experiences. Emotional maturity is based on respectful, warm responsiveness and wholeheartedness which permits firmness and gentleness with infants and children, with adults, with the self and with

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others, in the framework of accurate, sensitive perception, genuine feelings, and honest thinking, undistorted by a misused and abused imagination. Only then can the individual truly see and deal with real dangers to self-realization, and become a constructive force toward their eradication.

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## THE QUALITY OF THE ANALYST'S ATTENTION

MORTON B. CANTOR

*Compiled and edited from lectures on psychoanalytic technique given by the late Karen Horney at the American Institute for Psychoanalysis during the years 1946, 1950, 1951, and 1952. Further lectures in this series will appear in subsequent issues of the Journal.*

THE ANALYST'S attention includes understanding and the taking in of observations. This is to be differentiated from the passive receiving of impressions. For the analyst, attention is directing himself—mind and body—to the whole being of the patient, with the purposeful view toward action (therapy). It is not only the application of intellectual energy. We are focusing on getting a feeling for the patient, for his uniqueness, so that his differentness no longer feels strange to us. This is of fundamental importance. There are three aspects to the quality of the analyst's attention—whole heartedness, comprehensiveness and productiveness.

### WHOLE-HEARTEDNESS

The whole-hearted aspect of the analyst's attention involves observing with all one's capacities and faculties. Here we are listening, seeing, and feeling with our intuition, undivided interest,

reason, curiosity, and specialized knowledge. This knowledge involves awareness of our own selves, generalized professional knowledge and experience, and all that we are aware of in the particular patient. We are focusing ourselves as fully as we can on all the patient's communications, verbal and non-verbal.

Whole-heartedness is an ideal state, an approximation of one's own personal equation. It is the faculty of not being distracted, either by our own deeper problems or by situations which have upset us acutely. The mind is the analyst's tool, as is the equation of our total personality, and we have the obligation to keep this tool in good shape if we are to do such concentrated work with it.

As an example, Horney spoke of feeling herself yawning and being terribly tired while seeing a patient upon her return from a vacation. Doing some quick self-analysis, she thought of a letter she had received from an old friend reminiscing about the wonderful time they had enjoyed together. Horney became aware of the conflict between the recently completed life of full ease and the present return to concentration on other people. The patient

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had been talking about the movie, "Treasure Island." In it the cook who had been a compliant person became captain. It had been this which touched Horney's problem, namely, resuming responsibility. She felt alert again and the problem of tiredness was no longer disturbing.

Detached, alienated psychoanalysts who are living through their intellect may be good observers, acute listeners, and able to concentrate better because they are disturbed very little by their own feelings. They have an interest in their patient's problems, but are more interested in the structure of the person than in the human being. Not only must one's intellect and stored-up knowledge come into play, but also one's emotions in regard to analytic work. It means laying oneself open for all the numerous feelings that can exist between two people—not only curiosity, but likes, dislikes, dismay, disappointments, humor, hopefulness, anger, sympathy, and so forth. This may be disturbing at first, but in time, as all remnants of feelings are allowed to enter, it will gradually become less irritating and more rational. The emotions of the analyst which will arise will be geared more to the patient than to himself; that the *patient* is getting somewhere, instead of the analyst getting him there, will be the central issue.

With greater awareness of the patient, we may finally approach the ideal of whole-heartedness—a surrender to the work by letting all our faculties operate while nearly forgetting about ourselves. Horney compared this to surrendering oneself to music or getting a first impression of a work of art. As our knowledge and experience become an integral part of ourselves, we are barely conscious of all that we are while at the same time *being* all that we are. We

can then be freer to extend the boundaries of ourselves and be more open to the beings of others.

#### COMPREHENSIVENESS

After considering the analyst's availability and openness to himself and the patient, the next aspect of concern is the specific direction of our attention. In comprehensiveness, we strive for the ideal of taking in everything without focusing exclusively on a limited set of factors. Horney compared this to the driver of an automobile who has to be aware of the condition of his car, the roads, the weather, other cars. Gradually this concern becomes automatic, so that it doesn't interfere with effective functioning.

The equivalents in the analytic situation have been discussed in detail in the previous articles, "The Initial Interview"<sup>1,2</sup> and "Interpretations."<sup>3</sup> In relation to the comprehensive aspect of attention, Horney re-emphasized observation of the patient's tempo in therapy and how it changes, and thinking in the tenor and spirit of the patient's associations. We are talking here about the many different levels of awareness the analyst can sense and observe.

Are we paying attention to the pauses, pressures, and rhythm of what is going on? What is the quality of the eagerness to learn something, the active searching for something? Eagerness may be deceptive; glib interpretations without interest in the analyst's opinion may arise from the patient's need to show how much he knows. Is the eagerness only intellectual or primarily an eagerness to confess? Does the patient give the result of his self-analysis or does he arrive at it during the hour, letting the analyst participate?

It is important to observe what is changing in the patient's attitude. Is he

productive and is he now productive outside of the analytic hour, too? Is what he is saying pertinent, or is he floundering and scattering? Does he focus on the intrapsychic or the interpersonal features of his problems? Does he have a tendency to deal with concrete things or theoretical considerations? What is his reaction to what the analyst is saying?

On another level, how is the patient presenting himself? Is he merely complaining, feeling victimized, apologetic, or demanding? Does he talk about himself primarily in terms of others? Is he critical, grateful, over-grateful, on the defensive, or glorifying himself? Does he give very complex accounts? What does he omit? Does he talk with the aspect of doing as much as possible, or showing what he has learned?

In regard to feelings, does the patient only report them or does he experience them in the hour? The feeling of anger, relief, headaches, dizziness may often have a dramatic quality indicating that something is going on at an experiential level. Is there an attempt to look for deeper meaning to these feelings? Is the patient noting a sorry state of affairs, or really experiencing suffering?

With one patient who showed no outward manifestations of anxiety and had a desperate need not to experience it, the only way I could sense his anxiety was by the change in the tempo and spirit of the hour. Suddenly he would mention ten or fifteen different problems in passing and I felt myself getting slightly dizzy and breathless, as if I had been trying to catch a butterfly. It was only by paying attention to my own emerging feelings that I could get a picture of what was going on.

To approach the goal of comprehensiveness in our attention, we need to be flexible enough to take in all those var-

ious elements as they come up. Horney talked about listening idly, avoiding a pin-point concentration which can close us off from a truly holistic view of the patient. In this regard, she mentioned the definition of a learned person as one who has forgotten a great deal of detail because he can afford to put it aside. The learning process leads to learning more and experiencing more freely, with the focus on our own individual theoretical concepts *arising from* this. We must also be careful not to let the intensity of our attention convert a mutual analytic situation into one where the patient is in the brilliant spotlight on a clinical stage while we are in the darkened audience. With both of us sharing more subdued light in the same room, we can become more open and real to one another.

#### PRODUCTIVENESS

While we listen and observe, something comes to our minds and quite unconsciously a pattern may form. We may not always be sure what is going on, but it may come after an individual hour, the next day, or much later on, depending on our availability to ourselves and to the patient. Is what is going on in our attention to the analytic situation productive?

We talk of productiveness in the sense of starting something going. What is really changing and what has to be tackled further? Are trends and solutions less compulsive and feelings more alive? Is the patient more aware of understanding his own drives and desires? Is he more confident in the analyst, more independent, more accepting of responsibility? Are there fewer neurotic symptoms and fears of conflicts? Perhaps there are more physical symptoms in the patient who has heretofore not been close enough to his physical

being to be aware of bodily participation in emotional conflict.

A woman began analysis with a vague feeling that something must be wrong. After two years she was still denying any deeper conflicts, resisting the concept that her dreams or slips of the tongue had any meaning; analysis seemed to be at a standstill. There was no evidence of psychosomatic symptomatology; nothing could be specifically pointed out to her that she could accept as an indication of anxiety. I confessed a concern about a "stalemate" in the analytic situation and said, "We'll have to light a fire under you if we're going to get anywhere." That night she developed her first psychosomatic symptom, a painful burning and itching around her anus. For the first time she began to seriously consider that there was a connection between physical and emotional processes, that there were unconscious forces operating within her, and that perhaps a person was something more than a rational human being operating behavioristically to overt aspects of his environment.

The ever-present question is: "Is what is going on now leading to self-awareness and bringing us closer to self-realization?" This applies on all levels—the doctor-patient relationship, the patient's life outside of the analysis, the description of an event or feeling, the discussion of a dream or interpretation, free-association, and what is going on within the analyst himself. How much can have happened with the patient in analysis if nothing happened to us while working with him? In a successful analysis, something happens to both people. If the analyst is merely a catalytic agent and nothing has changed in him, how much really could have gone on within the patient?

#### ATTITUDES INTERFERING WITH THE QUALITY OF ATTENTION

Many of the attitudes interfering with the analyst's attention have been discussed in "The Analyst's Personal Equation."<sup>4</sup> The analyst who is trying to get places in a hurry, rushing toward an understanding, will be impaired in terms of whole-heartedness, comprehensiveness, and productiveness. This may result from his own "shoulds," pride in omniscience and intolerance toward being confused, and from avoiding being in anxiety and conflict himself. His own egocentricity will interfere with his whole-heartedness. A one-sided view of what is going on within the patient may also be part of where the analyst is in terms of his own self-analysis (e.g., focusing on self-effacement and minimizing expansiveness).

Approaching the patient with preconceived ideas restricts comprehensiveness. Freud coined the term "free-floating attention," but for him much of this was an intellectual floating concerned with fitting what he observed clinically into the theories he was formulating. This may be done with anyone's own theoretical formulations. Here is the advantage to a theory with a general framework. The theory should never be more important than the patient. It should serve only as a blueprint. Of course, no one can be free of all one-sidedness, but from the point of theory as a background and with enlarging experience, the analyst can reach a more constructive balance.

#### IS ANALYSIS AN ART OR A SCIENCE?

Considering all the elements involved in the analyst's attention, the discussion led to whether analysis was an Art or a Science. Horney felt that people who say it is an Art may wish to discredit

analysis as merely a talent, something that someone is born with. Science can't tell you about *your* dog, but about dogs in general. This may help you, but to know *your* dog, you must live with him. In this sense, personal knowledge and understanding rather than generalities are considered Art.

Analysis is more critique than criticism, an appraisal of all aspects of what is going on rather than a judgment *about* them. We are more concerned with the information communicated to us by the patient than with knowledge of the patient in an abstract sense. Analysis must not be purely "objective" to be scientific. It is scientific in

the broad sense of seeking for what is, seeing patterns and cause-and-effect, having a method and an element of predicting future events. But it is also an Art in the sense of creativity, freeing the way for a change of structure and helping to bring about that which is more harmonious with full living.

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# REDISCOVERY OF TRUST

EDITH WEIGERT

THE MODERN psychoanalytic interest in ego psychology elaborated by Hartmann, Kris and Loewenstein<sup>1</sup> and broadened by the sociological studies of Erikson<sup>2</sup> emphasizes the integrative functions of the ego. This modern ego psychology has brought psychoanalysts closer to the viewpoints of phenomenology and existential philosophy which have been introduced into psychiatry by Freud's lifelong friend Ludwig Binswanger,<sup>3</sup> by Minkowski,<sup>4</sup> Boss,<sup>5</sup> Erwin Strauss,<sup>6</sup> and others. There are interesting parallels between Sullivan's studies of interpersonal relations,<sup>7</sup> Horney's ideas about self-realization,<sup>8</sup> Fromm's concept of freedom,<sup>9</sup>—all of these ideas and theories conceived in the United States, and Binswanger's "dual mode of existence,"<sup>3</sup> Martin Buber's "I-Thou relation"<sup>10</sup> and Berdyaev's idea about personal freedom,<sup>11</sup> which stem from the other side of the Atlantic Ocean.

The merely scientific approach necessarily reduces a person under investigation to an object, a thing, an It. In contrast to the Thou of an interpersonal relation, an It is predictable material resulting from chains of cause and effect, to be grasped, defined, compared,

and demonstrated to other observers. But the human being is not only a product of nature, nor is his development merely determined by a predictable course of history. The synthetic function of the ego does not create a closed, static system. Personality arises out of a creative process, surprisingly ever anew, integrating all that can become I to Thou. On one level, personality remains unpredictably free and open to its world and its future, although the freedom of creativity congeals ever again in the rigidities of inevitable objectivation. Personality is shaping its world and this world shapes the ego by processes of integration and disintegration which Freud reduced to objectified concepts of Eros and Thanatos, the life and death instincts.

From a subjective point of view the creative process of integration between the individual and his world is experienced at times more as joy, at other times more as pain. If intolerable pain or anxious anticipation of pain prevails, the creative process of development is interrupted partially by defensive neurotic or psychotic stagnations. The creative potentialities of I-Thou

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relations, the openness of a personality to the future and to its world is reflected in the experience of trust; a recoiling from the future and a threatening world is experienced as anguished loneliness.

Manifestations of trust and loneliness reach as far back as the dawn of a child's notion of his separate existence, of his emergence from the primordial symbiosis with his mother. Martin Buber speaks about the child who awakens at night, all alone in a dark room. All the horrors of the world (Binswanger's "naked horror") beset the child, unless he is able to remember that there is a mother in the next room, a mother that can be trusted, whose face does not lie. The world cannot be completely evil if such a mother is living for him. But if such an experience were completely missing, the child would have to see his world as a dangerous jungle, where everybody is at everybody's throat (Melanie Klein's "paranoid position").<sup>12</sup> The lonely child who cannot trust is endangered in his survival, as René Spitz has demonstrated in his work on anaclytic depressions.<sup>13</sup> Ungratified needs, such as hunger, thirst, and frustrated sexual desire, are distressing. Each frustration is experienced as a partial annihilation of the ego. But out of the world of frustration rises the imagination and the trust in future fulfillment. Delay of gratification can be endured if there is hope and faith. The desperately lonely individual can't stand frustration. His hopes degenerate into illusions and delusions to strengthen the hurt narcissism. The lonely person may learn to channel the rage of frustration into skillful manipulations by which he handles men like things, forcing them to grant compensations for the despair of loneliness. Such compulsive manipulations remain unsatisfactory. Only a relation

of trust grants the freedom to arrive at a creative integration of needs. It implies a daring risk, it does not enforce gratifications, since no amount of enforced gratification of isolated needs in a lonely individual can substitute for the over-all sense of confirmed existence which rises from a relation of trust that makes the child—and later the adult—at home in a world that surrounds Being with the horrors of Non-being.

The existentialists from Kierkegaard to Sartre<sup>14</sup> and Heidegger<sup>15</sup> talk about the horrors of nothingness, of non-being. They appeal to the lonely individual, "thrown into existence," lost in a mass society, to face bravely his fundamentally lonely, unique, and finite existence, to face death, the forms of partial death that penetrate life, but are covered by repression and denial. These philosophers appeal to modern man to rise out of the impersonality of the "Man," the "other-directedness" of Riesman<sup>16</sup> which anxiously manipulates an adjustment to the currents of mass society, to rise to the authenticity and uniqueness of his "being-in-the-world," to accept the limited freedom and the responsibility of his decisions, the inevitable tragedy of existence in what Berdyaev calls a fallen world. Heidegger's care (*Sorge*) can rise to Tillich's "ultimate concern" that transcends—ever again—the meaninglessness and powerlessness of a lonely existence. Man can free himself from the shackles of a defensive narcissism and broaden his being-in-the-world to a being-with and caring-for others.

There is no time to discuss the experiments of isolation that have been carried out by Hebb in Montreal<sup>17</sup> and Lilly at the National Institute for Health in Washington, D. C.<sup>18</sup> They indicate the regression in loneliness from the secondary to the primary proc-

ess of mental functioning. They also show that out of loneliness and despair can arise a new inner security and a new integration on a deep and basic level. Similarly, the meditating mystic or the creative genius transcend the anguish of loneliness in a creative act.

Also psychotherapy gives the patient an opportunity to relive the anguish of desertion and to rediscover the potentialities of trust. Experiences of loneliness are so dreadful that the individual is automatically defended against reliving and transcending them by the danger signal of anxiety. This mobilizes the forces of resistance and the repetitive defenses of transference. The patient sees the analyst at first as a ghost of the past, a parent who cannot be trusted, a partner who threatens the patient's identity, enslaving him in dependency, mobilizing castration anxiety and penis envy. He sees him as a representative of an archaic absolutistic morality. The patient can't yet meet the therapist in an I-Thou relation. Out of his egocentric defensiveness the patient tries to manipulate the therapist like a thing, an object to be bribed or exploited, used for protection or comfort, for the discharge of revenge or contempt. A patient said to me: "You are the thing that has to get me well." The therapist is not yet a living partner for him, but an It, a means to establish a defensive pseudosecurity that maintains the stagnations of a hampered development.

The psychoanalyst, on the basis of his training, has shed as far as possible the restriction that any kind of self-absorption imposes on interpersonal relations—namely, the wish to justify his own existence by success, to prove his theories or to gain immediate or vicarious gratification at any cost. Analysis has to be carried out in abstinence. Out

of the very void and anguish of frustration rises the yearning of trust in the patient. This basic yearning gives therapy a chance. The psychoanalyst, as Freud<sup>10</sup> has pointed out, works like a sculptor,<sup>6</sup> who removes the layers of encrusting material to free the *Gestalt* of the patient, as the gift of intuition can visualize it. The analyst needs the tools of science to work through the layers of resistance. But he must also be able to transcend the subject-object split of science, moved by the spirit that inspires the artist. Beyond the agitation of anguish he sees the patient's creative potentialities, open to the future, open to his world. Not all that occurs between therapist and patient is transference and counter-transference which, positively or negatively colored, repeats infantile dissociations, preserves an oppressive, hidden loneliness. Through the clouds of obscuring self-isolation and defensive pseudo-attachment break the rays of creative understanding. They lead to the rediscovery of trust. Trust is not merely an emotion, it is a response of the total personality. In adult life trust is experienced as choice, as decision, as commitment. In a rediscovered relation of trust the patient is able to unfreeze his defenses against anxiety and loneliness. This rediscovery opens new alternatives in the process of integration. It turns subjective experience from the despair of non-being to the hope of being, to the willingness to accept the limited freedom and responsibility of the personality's unique, authentic existence, its self-realization.

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# PSYCHOANALYSIS IN GROUPS: THE ROLE OF VALUES

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THE GROWING awareness that the analyst, too, is human and the increasing emphasis on his personality, his values, and his strengths and weaknesses, are characteristic of the recent period in the history of psychoanalysis. There was a time when the therapist was not supposed to have or to express values, when the emergence of values in therapy was viewed as anti-therapeutic. In itself, such an attitude is a reflection of values.

As we see it, all people, including patients and analysts, have values. Part of our task is to make explicit the values which often remain implicit. We are presenting a philosophic paper based on clinical experience. We are raising a large number of questions about which we have done some thinking.

What do we mean by values? A value is that which is good. The word *good* is synonymous with *values*. By good is meant ethical. So when we say values, we are speaking about what we believe is good. In psychologic terms, values are long-range attitudes, convictions,

wishes, hopes, dreams, faith. They are what we hold near and dear and good. These are values; the principles we live and die for, so to speak.

Values, then, lie largely in the realm of ethics and ethical behavior. They have to do with attitudes, motivations, and convictions, with real and fancied choices. They are primarily social in scope and application. Their sphere lies in all human conduct in which significant alternatives are available. A choice must exist, and we choose one mode of behavior as better when compared with another. Values are always hierarchically integrated; that is, they are related in terms of a greater or lesser degree of desirability. Without choice there is no value judgment. What determines one's choice is the sense of values. This is what we mean by values.

Some therapists, for example, hold as good what we would hold as bad; and we hold as good what others do not believe is valuable. Some do not believe that the very fact that you are part of a group is good. They think that being

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alone with somebody is better. Perhaps neither of these alternatives in and of itself is good, but still another choice: a combination of a happy, appropriate, reasonable, and significant measure of each of these varieties of experience.<sup>1, 2</sup>

We also want to raise the question whether what is therapeutically good is also healthy. Are values synonymous with health? As healers, as practitioners of the healing arts, may we affirm that anything that is healing, anything that is health-promoting, is good and whatever is health-denying or health-depriving is *ipso facto* bad? Can values, in this way, be translated into terms of health?

The therapist has values, the patient has values, and there are prevailing values in the community. Need these sets of values be consonant with one another, - need they be in harmony? Need the values of the therapist and the patient be congruent? How much divergence can be tolerated? Clinical experience, for instance, seems to indicate that when the values in the family are significantly different from the values in the community, problems arise in the children. If the values of the therapist and the values of the community are significantly different, will such a state of affairs lead to problems in patients?<sup>3, 4, 5</sup> Can the therapist do therapy and yet hold that certain conditions are health-giving if the community holds that they are health-denying, or the reverse?

Are there, moreover, general values, general human values, that supersede the particular therapeutic situation and specifically therapeutic values? Need they always be the same or are they always different? Can good therapy be done if these basic human values are in opposition to the values of therapy?<sup>6, 7</sup>

We think it is good that a therapist has values and we hope they are con-

structive values, for they will determine the effectiveness of his therapy. The therapist has values whether or not he admits or is aware of them. They are important in his selection of patients, his treatment practices, and his choice of goals. We wish to help make conscious the values of the therapist, especially the analyst who works in groups, to bring into awareness what his values are, so that those which are bad may be scrutinized, rejected, and worked through. Those that are good can then consciously be fostered, facilitated, and reinforced. Nor do we believe that the therapist must have only mild values, as some analysts think, as if strong convictions and strong feelings are *prima facie* bad. We feel, on the contrary, that the analyst's attitude of not wanting to take a firm and consistent position is bad.

We shall now attempt to specify some of the general human values, some of those related to psychoanalysis, and more especially those that are specific to doing psychoanalysis in groups. No claim is made that we have thoroughly explored any of them or that our list is exhaustive.

1. The therapist's choice to do therapy in an individual or group situation is an expression of his values. The way the therapist perceives what is good and what is bad in himself and in the group affects the quality of the therapy. A dominating or authoritarian therapist, for instance, who sees the group as one person or who will not let the group meet as peers without him, may not do therapy as well as the individual therapist. He may demand extraordinary superego controls. But the patient stands a better chance of achieving a wholesome set of democratic and constructive attitudes toward his peers and the therapist in a group situation than

with an authoritarian analyst alone.<sup>2, 8</sup>

A therapist can influence patients to become very much like himself, extensions of himself, or submissive borderline egos who act out his schizoid or conflictual demands, or who act out their own id forces. Whatever the therapist's attitude—whether he is too detached, or too aggressive, too overbearing or too compliant, too rational or too irrational—his problems can be better coped with by a group of patients than by the isolated patient. This is not to say that we go along with the belief that the therapist's problems are treated by the group.<sup>9, 10</sup>

The resources of patients can be better mobilized by their interaction in a group setting than when having to deal with the therapist's problems in an exclusive, dyadic relationship. Patients working together in a group are likely to be better able to resist the therapist's irrational demands or his emphasis upon pathology than patients who work with the therapist alone. The choice of a group as the medium for therapy by the therapist as well as the patient is recognition of how the group setting can be a factor in moving the patient as well as the therapist toward more wholesome values.

2. The group is a radical departure from the position of the patient on the couch, with the analyst seated behind. It is a geographic set-up in which the patient is seated facing not only the therapist but also his co-patients. He is forced into interpersonal interaction and intrapsychic exploration. The value of forced interaction already has been demonstrated for the dependent, passive, detached, and isolated patient. Most people in our society, though seemingly interactive, in many respects are really very isolated. In the group, patients have to look at one another

and at the therapist. Out of forced interaction, we move toward intrapsychic exploration.<sup>11</sup>

When a patient sits in a group and does not look at the people he is going around on, when he sits gazing at the floor, group members soon complain that he is not looking at them, that he is not involved with them, that they want to see his eyes, they want him to talk to them. If he starts speaking to one member and the whole group does not hear, they demand that he be heard. If he addresses himself exclusively to the therapist, the group protests. The group forces interaction.

How different this is from the traditional analytic arrangement. An individual analyst, for example, came to his supervisor and complained that for the past months the patient on the couch had spoken so softly that he did not hear her. What should he do about it? He was very surprised when the supervisor said, "Why not ask her to talk a little more loudly?" This could never happen in a group. Another instance is that of the patient on the couch who would fall asleep early in each session. The therapist took the position that if the patient felt like going to sleep, this was all right with him. Then there is the therapist who writes his letters, papers, and books while the patient is on the couch.

Some analysts seem too ready to permit the patient to isolate himself in intrapsychic fantasy, pathology, or sleep. Such a therapist permits—and sometimes even encourages—no interaction. He rationalizes this behavior by saying that he must encourage, teach, or develop frustration tolerance in the patient. Supposedly, one learns better to tolerate frustration by experiencing more frustration. We feel that one may be better able to tolerate frustration by

being secure, by being less anxious, rather than by experiencing continuing frustration.

The principle of forced interaction is an important therapeutic process in the group. From the inception of psychoanalysis in groups, patients have been asked to "go around," to involve everybody in interaction.<sup>2, 8, 11</sup> From the interpersonal transactions we then can examine the behavior in terms of what stands in the way of more wholesome interaction. This is an important and constructive principle which both the patient and the therapist in the dyadic relationship often abandon.

We wish to warn against the practice of some therapists compulsively to impose pathologic interaction between patients and therapist and among patients.<sup>9, 10</sup> This is a seeming, pseudo-interaction which is really non-communicative, fragmented and fragmenting, transference and counter-transference. Our concept is quite different from that kind of forced, pathologic non-interaction in isolation. For us, the individual also must be given the opportunity to explore his own intrapsychic processes on a reasonable, healthy basis. In addition, he must have an opportunity for genuine, appropriate, and realistic intercommunication.<sup>12, 13</sup>

3. In choosing to do psychoanalysis in groups, the therapist is expressing a belief that out of conflict and controversy come gains. In the group, patients become more aware of their differences and disagreements.<sup>14</sup> They learn to reach compromises, a more harmonious balance. They learn to sublimate some of their wishes, make concessions to one another, and be more flexible with each other. The therapist necessarily must examine conflict, difference, disharmony, disagreement and help patients to reach some sort of harmonious, rel-

ative agreement in compromise. What the therapist values in this scheme is not conflict for itself but compromise, sublimation, the necessity to reach some partial fulfillment for the contestants.

4. The analyst who works in groups accepts the fact that the patient must examine critically not only himself but also others. The group therapist believes that it is socially, psychologically, politically, humanly valuable for the therapist, too, to put himself in the position of being examined, criticized, challenged, questioned, that this is a valuable experience for the patient and an important value in life. We do not mean to foster rebellion which may already be a problem of the patient. We distinguish between rebellion and the wholesome necessity to examine leaders or persons in authority positions. Patients often need to learn that they can have the right and the courage to examine leadership critically. The critical reactions of the individual patient to the individual analyst is not always rebellious and resistive.

The patient in individual analysis has no feedback except the analyst. There can be little or no consensual validation of his critical view of the analyst, who can irrationally maintain his position of omnipotence. The group, on the other hand, provides opportunity for sharing and comparing experiences, for confirming or denying whether the reaction to the therapist was transference or appropriate.

By virtue of the fact that he puts himself before a group, the group analyst exposes himself consciously to the possibility of criticism and the confirmation of its legitimacy. The therapist is not so different from other human beings that he can never be wrong. This makes him much more human

and leads to the possibility of greater equalization.

An individual analyst once said, "You know, if any patient of mine called me by my first name I would throw him out of analysis." It is not calling the analyst by his first name that we are proposing. What we are pointing out is the attitude that I, the therapist, must never be perceived as a human being, as having a first name, as having any name but "The Analyst," in the orthodox sense. The classic anonymity of the analyst prohibits his exposure to consensually validated, realistic criticism.

Distinction must be made, however, between our position and the concept of status denial where the analyst not only subjects himself to criticism, but becomes more of a patient than the patients themselves.<sup>10, 15</sup> This is not what we mean by the therapist being subject to critical examination by group members. We mean appropriate, critical reaction. We do not mean sponsoring or acceding to patients' or therapists' demands to establish a co-pathology, co-delinquency, or co-psychosis.

Implicit here is the right to criticize authority and the need of support for that right. Experimental and social psychology studies of the authoritarian personality<sup>3, 6</sup> support the value of being legitimately critical of authority, and also of the therapist making a legitimate mistake without having to hide behind the mask of anonymity, omnipotence, and omniscience. There are objectivity, critical value, and positive potentials also in patients, in peers, in the child, in subordinates.

5. We believe in the importance or the value of democracy. By democracy we mean not the absence of leadership or the absence of differences, but the value of each person in the interper-

sonal experience. A person has value in and of and for himself. Psychoanalysis in groups tends to encourage a more democratic way of relating. It rejects the absolutism of authority, the non-critical view of the therapist, and, at the same time, recognizes the value of peers. Not only parents, but also children have values; not only therapists, but also patients. The one does not exist without the other; together they constitute a reciprocal unit.

Interaction between therapist and patient is valuable, but so is the interaction among patients in the group. The interaction among peers is not only, always and exclusively negative, destructive, and pathologic. The nature of a relationship to a co-patient is different from a relationship with the therapist, but nevertheless of value. Peers permit the possibility of a patient not only to be helped but also to help; not only to be supported but also to support; not only to depend upon but also to be depended upon. It attenuates the fiction of the benevolent giving by one person, the therapist.<sup>2, 5</sup>

The fact that a therapist chooses to apply therapy in the group situation says something about his valuing and his wish to explore a patient's relationship to peers as well as to authority figures. He is interested in providing a medium for the exploration of horizontal as well as vertical relationships, and the necessity to work these through. Moreover, problems with the authority figure can be more readily worked through with the support the individual receives from peers. The group facilitates the working through of authority and peer problems because both vectors are simultaneously present. The interplay of authority and peer vectors is present also in the relation of one patient to another.<sup>1, 2, 8, 13, 16</sup>

The patient in individual treatment often feels that he has no value, no position, no status, no consideration, no ego, no adequacy, unless he is alone with the therapist. Alone with the therapist he has value, he is regarded, he is felt, he is considered, he is a person, but once he is with another person or a group of persons, he is lost, he is inadequate, he is inferior, he has no position, no status. Psychoanalysis in groups mitigates against the preservation of such an irrational attitude, which must be worked through whether it is considered in the therapy group, in the family, in society, or in a democratic community. Such a patient needs to learn that he has position, status, equality, an ego; that he is a person who is valued, valuable to others and to himself; that his contributions are important; that we value him in the community and the therapeutic group.

A common problem of patients is the difficulty they have in viewing themselves as peers, as equals. For example, whenever one man in a group was asked whether he was anybody's equal, characteristically said, "No! I'm either superior to the next fellow or I'm inferior. I am never equal." He sees himself compulsively in this hierarchical position. We all suffer from this attitude in some degree. Perhaps, in some respects, it is also a true perception; in other respects, it is a distorted perception. The reality is that we are different. The question is whether this difference really makes us unequal. The group permits one to explore and understand differences.

6. Differences are not to be ignored. The demand of society, of parents and even of psychoanalysts for conformity, adjustment, and sameness contains a denial of the value of difference. The preference among some group thera-

pists for homogeneity is, in our opinion, the less valuable choice for the organization of therapy groups, for it reflects an attitude that tends to deny individual differences.

Differences can have equal value, but difference and equality are not on the same continuum. One can be equal in difference, because differences can have equal usefulness, acceptability, and validity. In psychoanalysis in groups it is possible to lose the sense of uniqueness without losing the sense of difference. The feeling of being unique is very often involved in pathologic formations and can be worked through. A sense of uniqueness can be given up and yet the validity of being different can be accepted. One can have a private life as well as a public life; one-to-one relationships as well as relationships to groups. One can have an individual and a group relationship. These can and should be integrated. It is possible to integrate a difference and a sameness without having to take either extreme, in uniqueness or loss of difference.

In individual analysis the therapist says, "I am the analyst, you a patient. You may be superior to me as a philosopher, as a technician, as a teacher, as a butcher, as an athlete, or in many other ways, but here, as *analyst*, I am superior to you." In psychoanalysis in groups, by providing a different atmosphere of peers, the patient is able to work out this problem more readily. In the group, the patient experiences the difference between patient and therapist, but simultaneously the sameness of his status with regard to other patients; they are peers. Yet each one is different, even though in the status structure of the group therapeutic situation they all are on an equal level. They all are equal before the therapist. They all are equally valuable and

equally important to the therapist. The structure of equality and difference is conjointly present. They are men and women with different histories and different problems and in the group they can experience directly the possibility of being equal in the difference. This cannot be experienced first hand in the individual therapeutic situation.

The patient who feels he has no equals assumes that all human beings are hierarchically related. As long as he rigidly holds to this assumption he can never resolve the problem of equality and difference. Only when he accepts the fact that human beings can be horizontally related is the perception of equality in difference possible. There is no less value in the human quality of the person who is able to fulfill himself in his role in society as a mechanic than in that of the banker, or philosopher, or scientist. The difference in their contributions may be very great, and we may regard them differently, but without the mechanic the others cannot fulfill themselves in terms of their own life's plan. The fulfillment of the one is as necessary as of the other in order for humanity to progress. They have equality of necessity, of value, of responsibility, if you wish, in terms of the larger human picture. This does not mean that they are the same. It does not mean that they are equal in the sense of no difference. But they are equal in the sense that they have value, and we can hold the recognition of differences as being valuable in itself. The difference between male and female, between illness and health, between therapist and patient must not be obscured.

We are aware of the compulsive quest for diversity, which may then become the pathologic addiction to divisiveness and diversion. On the other

hand, science seeks to simplify in order to lead to clarification, but it does not deny diversity as a state of nature. The one-sided pursuit of sameness or difference can be equally pathologic and misleading.

7. We hold that there is an appropriate place for differences of opinion, even between analyst and patient; that controversy in and of itself is not bad, and that one can be critical, argue, and disagree and still be friends. We are opposed to those who believe it is base to think independently, to get into criticism and controversy.<sup>14</sup> Conformity and submission can be the only end products of such an attitude.<sup>2, 5, 17</sup>

This value is often neglected in the experience with the individual therapist because the patient does not really fight with the therapist, unless the therapist is counter-attacking. But in the peer situation of co-patients, it is possible for attack and counter-attack to occur and for the patients still to know that they can be friends. They can work together, despite the fact that they have attacked one another or even acted out with regard to one another. It is a striking admission on the part of new members of a therapy group when they indicate their amazement of how the others can express considerable ambivalence and hostility toward one another and yet walk out of a group meeting in the friendliest way and continue to work together. A new patient often feels startled by the way in which group members can dispute one another and still maintain a working relationship.<sup>8</sup>

We are aware of the patient who must compulsively fight every individual before he can show any affection. This is the only way in which he can relate. There are also patients who compulsively emphasize only their feelings of being different. To be able to

relate to only one kind of person, to be able to relate or function in only one way, is limiting and limited.

8. We reject absolutism, totalism, and exclusivism. The principle of multiple reactivity and complementation represents an important value of psychoanalysis in groups.<sup>1, 8, 13</sup> It leads each patient to question the particular nature of his compulsive activity. It demands of him an examination of his prior and present modes of living. It helps him explore the possibilities of functioning in different ways. Group members question each other about the particular ways their competitive patterns limit them. Patients are forced in their exchanges with one another to seek compromises, to find a golden mean, to give up a totally isolated and egocentric position. They learn to recognize the distortion in total potency or total impotency, and to struggle for the acceptance of partial human capacities in their interaction.

The therapist and the patient must learn to accept their similarity with other individuals and their difference, as well as the different roles each single individual is called upon to play in different situations and relationships.

In individual analysis there is generally only one kind of activity the patient can perform. He, the taker, is dependent upon the therapist, the giver. What the patient gives are his "free associations." This is his work, his giving. Theoretically, the role of listener is the therapist's; the patient does not have to listen. There is no real alteration of roles, in part due to the fact that the analyst has no right to seek fulfillment from the patient. When the patient becomes healthier and attempts to alter the nature of the roles, the therapist may interpret this as resistance and not permit the change.<sup>11</sup>

Psychoanalysis in groups sponsors the recognition of the necessity in all human relations to assume different roles. In the group, the patient can now, this moment, be helped; but it demands also that within a short space of time he be a helper, that while he is listened to now, shortly he must listen to the other. It demands of him now that he pay attention to his own feelings, but that the next moment he attend the feelings of the other; or even that in the moment of expressing his feelings, he must consider their impact upon the feeling of the other. Now he can be attentive to his own affect; in the next moment he must be reasonable about the feelings he has expressed. While he can give vent to his feelings, he must apply some reasonable attention to the needs of other people. While this moment he may be impulsive, the next he must be more considerate. This shifting of roles makes a healthy demand on him to be responsible and to relinquish the resistive and rigid pattern of an exclusive way of relating.

We have already suggested that an exclusive way of relating is limited, whether only with authority figures or only with peers, only in the one-to-one relationship or only in the group. Even in the group therapeutic situation, if the patient is always the giver, always the helper, this can be resistance. The occasional assumption of such a role is healthy, but always to be in the role of helper is just as unhealthy as always to be in the role of being helped. It is part of totalism.

We believe it is good that peers and authorities can be examined in the variety of their aspects because of the multiplicity of interactivity and stimulation. A person can relate to, be stimulated by, and interact with many

kinds of persons. In individual therapy, the patient must relate in a complementary way only to the therapist. In the group, the uniqueness of resources in the therapist is complemented by a multiple set of other persons. In the group, the patient has greater freedom to choose with whom to react, to what degree, and in what way. In individual analysis, the patient has no such choice except in reporting outside experience or in fantasy.

9. In psychoanalysis in groups the patient learns to understand that he has no right to expect from all people the same kind of detached, objective understanding that he gets from the therapist; that the therapist's position is, in some respects, artificial. The therapist does not behave this way in his relationships outside of the therapeutic situation. If the therapist is attacked outside of therapy, he may withdraw or counter-attack, or he may be hurt, or have a variety of human responses. If the therapist is always non-reactive to the patient's provocative role, then the patient never really learns to perceive his provocative role except insofar as the individual therapist wishes to interpret it as transference. The patient may, however, have a provocative role which is not always transference, but related to how he functions and what kind of person he is. With the therapist alone he may never become aware of how other people feel about him and how they see him. This benefit arises only in the therapeutic group.<sup>8</sup>

The patient also needs to learn about how his peers in the group react to him. In this way he comes to recognize the effects his rational and irrational expressions have produced in his peers in the group, as well as in society; in this way he gets to know his provocative roles, both positive and negative, with

regard to peers as well as authorities. He becomes aware also of the difference between his peers in the therapeutic group and those in the community.

The patient has no right to the exclusive possession of the therapist or the other person. This misconception exists even in marital situations where one partner will demand the total and exclusive possession of the other. Exclusive possessiveness is mitigated by the group. However, there may be patients, as for example, the severely orally dependent type, who need a period alone with the therapist, perhaps projected as mother, before they can make a more wholesome transition to siblings, to peers, to the group, and relinquish the exclusive possession of the therapist. It would be unreasonable to refuse to perceive the patient's irrational needs for exclusive possession and to demand that he forego them at the moment. For this reason, individual sessions where they are really needed are appropriate. It is bad, in our estimation, for a group therapist to say, "I never hold an individual session."<sup>1, 16</sup>

10. Just as relationship is important, we believe relationship cannot occur unless there is communication. Good communication is nonambiguous, open, direct, a free expression of feelings, thoughts and attitudes. One of the aims of any psychotherapy is to establish communication, for without verbal intercourse we cannot achieve real understanding.<sup>5, 13, 17</sup>

We think it is good if people have relatively uninhibited conversation with one another. Social intercourse can be relatively uninhibited. If one is as honest as is realistically appropriate to the relationship, this is a desirable kind of communication. We think that inter-communication, even in psycho-

analysis, is as important as intra-communication, that is, communication with oneself or one's own unconscious processes.<sup>2, 13</sup>

We believe that to interpret to patients that they have experienced telepathic communication and that this is the "real," the unconscious-to-unconscious communication, is destructive. We reject, moreover, the value some therapists put upon inappropriate or irrational means of communication, namely, in sleep, in dreams, in telepathy, in non-verbal contact.<sup>9, 10</sup> Their emphasis upon irrational and isolating pseudo-communication is a preoccupation with destructive values. We wonder how much they try, in their working through, to get the patient in therapy to communicate in a more appropriate way.

There are some people who can communicate in a one-to-one, private, secret relationship, whether good or bad. But the moment they are exposed to the more public situation of a group, they remain separated, withdrawn, detached, depressed, hesitant, and uncommunicative. Other people seem to be able to communicate only in the public relationship; in the group they seem related and interactive. In the intimacy of the one-to-one situation, they become isolated, hostile, anxious, uncommunicative. The presence or absence of the authority, the therapist, seems similarly to affect communication in some patients. Psychoanalysis in groups attempts, then, to provide a harmonious balance of individual and group experiences.<sup>1, 2, 8, 16</sup>

11. In contrast to some analysts who prize isolation, we hold that relating, interacting with other human beings, in and of itself is good. We hope that in the therapeutic situation we shall be able to examine the nature of that re-

lationship and to help make the relationship more constructive by working through the destructive elements and distortions and by fostering positive relatedness. But relating to other human beings, as such, is valuable, as opposed to insulation and separation, as such. Aloneness, the absence of social interaction, is dehumanizing.<sup>5</sup>

The group provides a happier medium for the evocation of problems in social living and the possibilities of a struggle toward their resolution. In its emphasis upon the interactive, the possibility of increased relatedness is offered by the group. If striving for equalization of parent and child, of teacher and student, of analyst and patient, is an objective in therapy, the attainment of this socialization is facilitated in the group by providing peers who can help the individual work through his tendency to attach himself to or over-invest in the authority figure, and finally come to a more wholesome approximation of equality.<sup>11</sup>

Socialization is vital to the development and preservation of man. A human being is a socialized, human animal. It seems to us valuable for him to be placed in a social context to humanize him further. The good therapist, whether he works with individuals or with groups, accepts the concept that man needs about him other human beings in order to mature, to be able to live adequately with other human beings. The analytic group is an excellent matrix in which to reconstruct the family, to provide an extra-familial group in which to make the transition from the projected family to non-familial wholesome associations, and to enable the patient to return more positively to his original family, once his projections have been worked through. Through his contact with other pa-

tients in the course of his struggle for growth, the patient learns to cooperate for the continuity and gratification of self and the group.

It is true that the patient in individual analysis may work out his problem with the family as reanimated in successive transference projections on the therapist. The group, however, facilitates the resolution of these problems because the whole canvas emerges more quickly and is, therefore, available for more lucid examination and working through. One gets a better picture of the multiple transferences operating in the family at the same time.<sup>2</sup>

12. We believe that the group has value in and of and for itself. This does not mean that we do not value individual experience in therapy and in life. Living in a group, experiencing interaction in a group, is a maturing, fostering and broadening experience for human beings. The individual exists only by virtue of the fact that there are groups, and the group by virtue of the fact that there are individuals.

The purpose of being in a therapeutic group, however, is not so much to live as to learn. Therapy and the therapeutic group exist to provide a learning experience. This objective must be clear to both patient and therapist. Here patients are learning how to live, but the living takes place not in the group, although it is a living experience, but outside the therapy group, outside of the function of therapy. It is in the therapeutic group that one learns to live better, to live with more fulfillment, to live more constructively with other individuals and groups.

The group therapist, however, must not be misled and allow the group interaction to become the patients' substitute for social living and socialization. The individual analyst, aware of

the aloneness of his patient, may encourage him to interact with other people and to socialize. The group therapist, providing a situation in which interaction with other people, the other patients, takes place, may tend to overlook the fact that this can be an isolating experience. Patients before they come into a therapy group may have relations with friends and family. They may give up these contacts and seemingly regress into the group and react exclusively with members of the group.

The ultimate objective of the therapeutic group, like the individual therapeutic experience, is that the patient will find social and sexual life and fulfillment outside of the relationship with the therapist and the other patients. This pitfall must be kept firmly in mind by the group therapist or he can become seduced by the apparency of interaction into encouraging the aloneness and isolation of the patients. Patients may misuse the therapy group as the invested experience of socializing and thereby isolate themselves as some patients isolate themselves within the individual therapy situation. This possibility must be consciously pursued by the group analyst, especially if he uses the alternate session, one of the benefits of which is socializing. By providing patients with such an opportunity, further isolation from the larger social group can occur.<sup>8, 9, 10, 16</sup>

Moreover, it is an error of psychoanalysis in groups to allow patients to see the subculture of the therapeutic group as a microcosm of the total society, to see all of society as a generalization of the therapeutic experience. As the patient gets better he should want to slough off his more pathologic associates. It is, therefore, not only resistance when, after improvement, a patient wants to leave the group. To view

this development only as resistance is to miss its positive implications. Furthermore, it is resistance to change for a patient not to want to leave the group, to resist getting well, because here is a controlled social life, a provided social life. Just as the family may be used as a means of not relating to people who are different, so the therapy group may be a way of not relating to or avoiding relationships with those who are different, those who are not members of the therapeutic group.

13. Although we see value in real belonging, we recognize a current, phony concept of belonging. It is often a pseudo-belonging as, for example, in the group patient's inability to attach himself positively to someone outside the group. It is an apparent, transferential, pseudo-belongingness that isolates him in therapeutic relationships.

This happens even in life. We are reminded of the case of a young woman whose father said, "You can belong to me and be loved by me, but only on my conditions, only on my terms." That is, only if she accepts the irrational demand of the superordinancy of the parent and the subordinancy of the child. This is a kind of transferential belonging which is different from real belonging. Transferential belonging can occur in the group, and the therapist may unwittingly encourage and accept it as if it were real. One sees pseudo-belongingness also in individual analytic relationships where, for example, the therapist develops an intimacy with his patient and sees her only during analytic sessions, but makes no real relationship with her outside of this fantasy one.

14. We reject the tendency among some group therapists to permit a pathologic subculture to develop where one patient will say to the next, "Well,

what do you want of me, that's my neurosis." This attitude is sometimes seen in individual analysis and is even cultivated by the individual therapist, when he tries, no matter what, to understand the patient and permits him to go on acting out his pathology.

Psychoanalysis in groups recognizes that the patient must become increasingly aware not only of himself but of others. This contrasts with more orthodox individual analysis where too often the patient becomes almost exclusively preoccupied with his own intrapsychic processes.<sup>13</sup> In such a case, we say, it is poor individual analysis. The group, however, by its very nature demands forced interaction and interpersonal communication. The patient must be attentive also to the problems and resources of the people around him. The group demands that he be creatively adaptive to the individuals with whom he is associating. He not only can adapt himself, but he tries to adapt the environmental situation to himself.

Psychoanalysis in groups precipitates areas of interpersonal conflict and forces the individual to scrutinize his and others' roles in creating the opposition, the impasse. The antagonists must seek means to resolve and work through the intrapsychic pathology that has led to the interpersonal conflict.<sup>11, 14</sup>

Psychotherapy has been too largely devoted to the elucidation of psychopathology and given less attention to the necessity for bringing out and developing the patient's healthy potentials.<sup>15</sup> Too little attention has been paid to the problem of working through.<sup>9</sup> In working with groups, one is impressed by the extent to which patients confront one another spontaneously and healthily with the demand to try constructive alternatives. Questions occur like, "Why don't you try

this?" Or, "Don't you see that . . . ?" Or, "Can't you make an effort to . . . ?" It is noteworthy that the group is generally more impatient with, less tolerant of, and less interested in psychopathology than the therapist. This is a positive value in human beings who are patients, who do not have the kind of interest, sometimes obsessive, that the therapist has in psychopathology.

15. We reject the view that health rises out of pathology. We see it, in its extreme, in the form of the "therapeutic psychosis." The assumption is made that out of illness, through the expression of pathology, you rid yourself of the demon that possesses you. Then you will be healthy. It is true that healthy potentials will be freer if the psychopathology is worked through. But we have the feeling that if we work more with the constructive potentials in patients, the freedom to use those potentials is increased and pathologic barriers to freedom will atrophy. But it is a misconception to believe that the source of what is health-giving, of what is constructive and creative, is the pathology. Some therapists value pathology more than health.<sup>9, 10, 18</sup>

We do not hold that catharsis results in health. Indeed, catharsis is valuable, but like pathology it is not the *via regia* to mental health. Merely to cathart, to express pathology, is not in itself curative. Something has to be done with it. To insist that it is healthy if one can express unconscious material directly is a mistaken value. It over-emphasizes intrapsychic material. Nor are psychodynamics equal to therapy. Psychodynamic knowledge, like diagnostic information, provides material for therapeutic work, but together they do not constitute the therapeutic process. This is *pars pro toto* reasoning. To view therapy and dynamics as one is to mis-

conceive the analysis of the dynamics as the cure. Moreover, psychodynamics and psychopathology are not the same. A good psychodynamic understanding of the patient includes all of his functioning, positive as well as negative. We want to know his motivations for health as well as unhealth.

With regard to psychoanalysis in groups, it is true that the group stimulates psychodynamics and that the alternate meeting in particular stimulates psychodynamics, but not only the psychodynamic pathology but also the psychodynamic healthy potentials in the patient are stimulated. What happens reconstructively depends on how the therapist uses the pathologic and healthy psychodynamics.

16. We feel it is valuable to understand that in all situations, including psychoanalysis in groups, there is structure, process, and content, and that each is related to the others. Values are implicit in which of these we stress and how we use each of these. Those who stress content, for example, generally miss the unconscious, the psychodynamic material. They miss also status and interaction problems which arise out of the nature of the structure. The structuring of the therapeutic process also implies values. To emphasize the structure as opposed to process or content, namely, in what setting, as opposed to how and with what material you choose to therapeutize, is also one-sided and non-discriminative. It leads to limited therapeutic results.<sup>1, 2</sup>

17. Psychoanalysis in groups provides an excellent opportunity to evaluate old values and learn new ones. As one experiences through interaction and inter-communication, and shares values, convictions, and attitudes with other members of the group, one learns to evaluate one's own traditional, famil-

ial values and, at the same time, to learn new values. Values arise in the interaction between individual and individual, group and group, and between the individual and the group. In the individual analytic situation only one of these three sources for the derivation of values is provided by the therapy. In psychoanalysis in groups, all three exist.<sup>2, 8, 10</sup>

The values we have discussed so far are those that have specificity with regard to psychoanalysis in groups. We feel that they have application to all therapy as well as to the individual in society. Nevertheless, we have omitted a number of genuine values, some of which we must list, no matter how briefly. We are not elaborating even those we include here, but we recognize that they lie *au fond* and provide the substructure for the values of psychoanalysis in groups.

1. We have reached an unfortunate point in psychology, as well as in the culture in general, where it is believed that experiencing and expressing affect are more enlightening than logic or reason. The value of intelligence and reason is often neglected. We are not advocating an exclusive view of human function. Affect and action also are valuable. Thinking, feeling, and doing must be integrated and the compulsive pursuit of any one of them to the exclusion of the others is not good. Nevertheless, we wish to state our belief that human desires may be directed by reason. "The voice of the intellect is a soft one, but it does not rest until it has gained a hearing," Freud said. "Ultimately, after endlessly repeated rebuffs, it succeeds. This is one of the few points in which one may be optimistic about the future of mankind, but in itself it signifies not a little."

2. We believe that there is value in

the funded wisdom of human experience. Culture, training, human interaction, and exchange are valuable. History and context must not be pursued in and for themselves, but they are useful.

3. We believe that flexibility and judgment are good.

4. We esteem educability and change. One of the ordeals of the psychotherapist is the patient's enduring resistance to change. Yet a patient with no resistance would be psychotic or the totally passive and dulled instrument of the therapist. In many ways it is overcoming the patient's resistance that makes psychoanalysis such a fascinating experience for the therapist. The patient's tempering his rigidity in the face of insight is an endlessly exciting and wonderful experience. It is intriguing to observe his opposition begin to defer to reality. The patient whose resistance takes the form of utter compliance is not nearly so interesting, until his passivity yields to self-assertive claims. But the possibility of change is one of the most stimulating, rational gratifications available to both patient and therapist.

5. A comprehensive view of human behavior includes not only the manifest act but also the motivation. Behavior and motivation may be consciously and/or unconsciously determined.

6. It is necessary for human beings to learn in the family, in therapy, and also in life the difference between right and wrong. In therapy the analyst must refuse to yield to a patient's pathology and in so doing strengthen the patient's sense of values. The sense of what is right and what is wrong is a consequence of human interaction, never of mystic intuitive inheritance.

7. Freedom is good. It implies a rejection of false necessity, of fate. We

mean the concept of choice, selectivity, discrimination, parity, and spontaneity. In freedom one can survey, understand, and accept the possibility of multiple alternatives and to make a choice within those. It implies, too, an awareness of responsibility in anticipating the consequences of the decision for the self and for others. We do not mean the encouragement of the illusion that limitlessness and license represent freedom. Liberty is not derived from acting on impulse or in compulsion. Too often the patient's and the therapist's insistence upon the "right" to have every kind of experience is simply a rationalization for acting in pathology. Their freedom is lost unless they discriminate sufficiently to choose reality as more valuable than oceanic fantasy.

8. Mutual aid and cooperation are good. Not only does the human being need to be supported, but also to support others; to protect and to be protected; to help and to be helped; to love and to be loved.

9. Since problem-solving is one of the characteristics of the human being, what facilitates this capacity is good. Psychoanalysis, science, rationality propose that problem-solving be based upon scrutiny, causality, observation, comparison, and reason rather than upon authority and revelation.

10. Finally, we hold as bad the growing tendency in current psychotherapy to reject training, clinical experience, social interaction, and rationality. Speculation and philosophizing need more than subjective confirmation. They must be based upon human experience and tested in clinical and life situations. The present withdrawal into mysticism among certain psychotherapists as a more adequate substitute for reason reflects a bewilderment and a sense of inadequacy before the inexorable

logic of science. An irrational school of therapists is regressing to magical notions of treatment while announcing them as an advance. For the idolatry of the past they are substituting glorified illusions that security lies only in the momentary satisfaction of pathologic strivings. But our experience shows that whenever we build a structure on unreasonable foundations, no good can come of it. We cannot gain more understanding by resigning our rational responsibilities or by resurrecting antiquated and cabalistic devices when sounder means are available. To relinquish our hard-won victories over mystification is to submit once again to a despotism of unreason and the destruction of values.

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# PERSONALITY DEVELOPMENT DURING GROUP PSYCHOTHERAPY

## ITS RELATION TO THE ETIOLOGY AND TREATMENT OF THE NEUROSES

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THE PURPOSE of the present paper is to demonstrate by empirical data the validity of the following five propositions concerning personality development, the etiology of the neuroses, and therapy.

1) During the process of personality growth each stage is a preparation for the next, the fulfillment of one being a necessary precedent for satisfactory development through the next; similarly, pathological development in one stage leads to pathological development in subsequent ones.

2) The pathological deviations in personality growth which culminate in development of the neuroses are caused principally by early (and continued) deprivation of basic emotional needs, combined with the acting out by parents, or significant others, of their own neurotic patterns upon the child.

3) The correction of such pathological deviations and the re-direction of the patient toward a healthy and ad-

justed maturity involves his learning how to secure from his present environment satisfaction of current needs.

4) Satisfaction of current needs can occur only following or during the patient's reevaluation of his self-concept and the realistic assessment of his actual abilities.

5) Such a new attitude toward himself, which is based upon the reality of his actual abilities, develops in therapy largely as the result of three related processes: the development, through interpretations, of insights into his unconscious motivations and the reasons for his past and present behavior; a new type of interpersonal relatedness; and the incorporation of a new and valid set of reflected appraisals.

### METHOD OF STUDY

The observations upon which the preceding formulations are based were secured during the treatment of 152

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patients by a combination of group and individual psychoanalysis. The groups consisted of from six to nine patients, both sexes being present in approximately equal numbers. No attempt was made to keep the groups uniform as to age, the variations being from twenty to fifty-four. The group sessions lasted from one and a half to two hours, and the groups met once or twice a week. Approximately one quarter of the patients were seen once a week in individual analytic sessions. The remainder were treated exclusively in the groups, except in times of crisis when they were seen individually as frequently as the circumstances indicated. The present studies were begun nine years ago and have been carried on continuously since that time. During the sessions the analyst took notes which were supplemented by further observations following the sessions.

#### EPOCHS OF PERSONALITY DEVELOPMENT

Sullivan<sup>1</sup> has described in detail the process of personality growth and has carefully formulated the basic emotional needs characteristic of each epoch. Briefly, these are as follows:

1. In *infancy* the most important needs are for tenderness, love, care, spontaneous affection and cuddling, bestowed upon the infant principally by the mother, but also by significant others. When these needs are satisfied the infant develops a sense of security which is based upon the repeated experience that his needs are met and consequently will continue to be met.

2. In *childhood* the most important needs are for tenderness and care, for participants, and for affectionate physical contact. The participants of greatest significance are the parents or parental substitutes.

3. In the *juvenile* epoch the most important need is for peers with whom the juvenile can share his experiences and begin to evaluate the limitations and peculiarities of his home.

4. In *preadolescence* the most important need is for personal intimacy and its satisfaction through friendship with a *chum*.

5. In *adolescence* the principal need is for an intimate relationship with a person of the opposite sex.

#### CLINICAL DATA

The evidence for the preceding formulations will be presented by describing the case history of a member of one of the groups, pointing out specifically the nature of the deprivations, the kind of acting-out by the parents, the resulting self-image and subsequent personality deviations, the methods used in therapy, and the patient's response to them. This patient was seen privately twice a week for eight sessions prior to his introduction into a group. He was not seen privately subsequently, except in times of crisis. The group in which he was placed met twice a week during the first year and a half, and once a week after that time.

Al was a twenty-nine-year old clerk in a large office. Although he had a Master's degree in history and had taught two years in high school, he had drifted into uncongenial work because of difficulty with his students and with his principal. Physically, Al was small in stature and slightly stooped. His delicate features had an appealing quality. Subsequent experience, however, showed that underneath this exterior there lay a deep resentment which expressed itself on occasion in acts ranging from childish temper tantrums to physical violence.

Al's father, a day laborer, was a Polish immigrant. Uneducated and crude in manner, he dominated the entire family in a harsh, tyrannical fashion. He was proud of his own physical strength and criticized Al, saying that he was weak; another way in which he derogated Al was to tell him he was stupid. His attitude of contempt and ridicule made Al feel helpless and inferior. These feelings of inferiority were further entrenched by his relationship with his older brother, whom his father always praised as stronger and more capable.

Al's mother was a kind woman, but she was over-anxious. Unable to love her brutal husband, she lavished affection upon Al and babied and over-indulged him. Although she pampered him, she lacked the capacity to defend him from his father's attacks. This was taken by Al as tacit approval of his father's judgment and reinforced his feelings of weakness and stupidity.

Because of the nature of Al's relationship with his family, he was unable to relate to the other children when he entered grammar school. He was afraid of being attacked, he felt inferior and inadequate, and he had an excessive need to be babied and protected. His classmates ridiculed his childish behavior and as a result Al withdrew and did not become a member of a juvenile group. Consequently he did not learn how to share his experiences with his peers, nor did he begin to evaluate the limitations and peculiarities of his home as is usually done in the juvenile period.

When Al reached the chronological age of preadolescence he had had no experience in sharing his feelings with others, nor did he know how to respond naturally to the spontaneous feelings of his contemporaries. He felt isolated.

This feeling of isolation was further increased by his failure to form a chum relationship. Similarly, in adolescence he was afraid to make overtures to girls of his own age, and his passivity and inability to share were not attractive to them. The one experience he had was with an older woman and this relationship ended unhappily.

From this brief summary of Al's development it is apparent that initially he would have difficulty in relating to the members of an analytic group. This was apparent from the way he reacted at first to the group process. He had no idea of how to participate and instead of sharing his experiences with the others and listening to theirs, he continuously sought expressions of sympathy and pity. When he did not receive them he withdrew and sat staring into space, depressed and angry. His associations led to his recalling the intense fear and anger he had felt when attacked by his father and the dependence he had placed upon his mother's pity and anxious concern. The analyst suggested to Al that his frequent appeals for pity from the group were based upon his mother's excessive concern and pity for him. He did not realize that he was acting out in the group the kind of relationship he had had with his parents, and when this was pointed out by the analyst he was initially unable to understand or accept it.

Al's description of his father's brutality was met with expressions of sympathy and concern from the group members. They vigorously condemned his father's behavior and said that although it was true that as a child Al was naturally weaker than his father and older brother, this should have no effect upon his current attitude toward himself, since at the present time he was physically adequate. The various

members of the group also said that his father's derogation of him as weak when he was a child was an evidence of his own neurotic need to dominate. The analyst agreed with this and also with the statement by several of the group members that Al's father had been incorrect in calling him stupid, since it was obvious that he was unusually intelligent. At first Al insisted that his father's appraisal of him was accurate in every way. It was only after this was repeatedly discussed and Al's real accomplishments (such as having secured a Master's degree in history) were pointed out again and again that he began to see that his negative view of himself was based upon his father's distortions.

By the end of the first year, through repeated analysis of his distortions and resistances, coupled with positive appraisals from the group members and the analyst, Al began to develop some insight into the reasons for his behavior and into his unconscious motivations. He began to learn how to share with the other group members and with the analyst experiences that were deeply personal in nature. This helped to make up for his deprivation in sharing his experiences with his peers in the juvenile epoch and for the lack of his evaluation of the peculiarities and limitations of his home at that time.

At about this time in his therapy, Al developed a close relationship with an associate at his place of work, an older man. He spent a great deal of time with this man and shared experiences with him in an intimate fashion which had never been present in any of his previous relationships outside of the group. This relationship had about it many of the characteristics of a father-son companionship and had positive and constructive aspects in that the

man was kind to Al and gave him the advice and reassurance a good father would give.

Toward the end of his second year of therapy Al began to develop a chum-like relationship with a young man in the group. He visited his home, exchanged confidences with him, talked with his mother. He said that for the first time he felt comfortable and accepted by a person his own age. This partially compensated for the lack of a chum relationship in preadolescence.

Associated with the later stages of this chum relationship were his first adolescent approaches to women. The manner in which Al worked through his fear of forming an intimate relationship with a member of the opposite sex illustrates the way in which the group process, supplemented by occasional individual analytic sessions, facilitates the working through of a particular problem. Although Al had strong sexual desires he was too threatened by women to make any sexual approaches. He spoke frequently of his intense loneliness and his desire for feminine companionship. He said there were a few girls who attracted him at his place of employment. Although they ate lunch in the same cafeteria every day, he was afraid to speak to them. He said that on one occasion one of the girls sat down beside him and he was excited, but too frightened to speak to her. This was met with expressions of astonishment by the group members and assurances that the girl would have liked him to talk to her. This led Al to disclose that he felt no girl would be interested in him because he felt he was not physically attractive to women. Three of the girls in the group whom Al liked immediately said they felt he was attractive as a man—a disclosure which Al at first greeted

with incredulity and amazement. However, he still remained unable to make any approach to girls and this led the analyst to suggest that in addition to his fear of not being accepted because of his physique, there might be additional and deeper causes for his fear of rejection.

Al said that he felt dull and uninteresting and unable to carry on a conversation that would interest girls. With the therapist's help, he then recalled that he had never been able to get through to his father and that this had created in him a deep fear that he would be boring. It was suggested to Al that perhaps he felt he had to put on a "performance" for a girl, but the fact was that he had held the attention of both the group and the analyst by being his natural self. It was pointed out that although he was not aware of it, when he was at ease in the group he was both dramatic and articulate.

Some time after this Al told with tremendous pride of having had lunch with one of the girls in his office. The group responded as a unit with praise, which by this time in his therapy Al was able to accept with pleasure. This represented a partial fulfillment of his childhood need for praise and affection.

Later, Al fell in love with a married woman several years his senior, and this was partially reciprocated. This illustrates again his initial dependence upon an older person. He described very vividly an instance in which he violently threw his arms around her and kissed her so aggressively that what he remembered most clearly was the clicking of their teeth. This incident as described by Al was accompanied by feelings of fear of reprisal from the woman's husband. In associating to this, Al remembered similar feelings that he had had toward his own father. He re-

called lying awake at night on several occasions as a child, listening to his father and mother having intercourse in the next room. He felt guilty about listening and he was afraid he would be discovered. He thought his father was hurting his mother and he wanted to protect her, but was afraid. Al transferred this impression of his father hurting his mother to the sex act, and came to associate sex with aggression.

The dream material he presented in the group showed deep feelings of attachments to and sexual attraction for his mother. On one occasion he dreamed that he was sitting astride his mother's stomach, playing with her breasts. We see here material indicating the deep fear Al had of his father, its association with sex, and his dependence upon and attraction to his mother. It is obvious that a carry-over of this constellation of feelings would seriously interfere with spontaneous relationships with members of the opposite sex. It also increased his fear of authority, as will be indicated later in discussing the analysis of his feelings of hostility.

The analyst suggested to Al that his relationship with the older woman was an "acting out" of his original feelings toward his mother. An additional factor was his fear of rejection by a girl his own age. With continued discussion Al gradually began to feel he would like to terminate the relationship. In this he was particularly encouraged by two girls in the group who were interested in him, and of whom he was fond.

In the interim between Al's terminating his relationship with the wife and his establishment of a new relationship, his attraction to one of the girls in the group, Ivy, who had encouraged him to leave, increased in intensity. Again Al's choice was of an unavailable woman, as Ivy was engaged. One improvement

should be noted, however. Ivy was the same age as Al, not several years older.

In spite of Ivy's engagement, Al fell violently in love with her, and when she talked about her marriage plans he felt helpless and abandoned. One night he met Ivy outside of the group and said that he saw himself as ending up alone and jobless, looking out of a window in a small room, with suicide as his only end. This was Al's ingrained picture of himself which had haunted him all of his life and which he used in an attempt to get sympathy. At this time Ivy recognized that she had allowed Al to play upon her sympathy and refused to give him the smothering pity that he demanded. Confronted with this refusal Al became aggressive and tried to force Ivy to make love to him. Ivy refused. Faced with the failure of his two basic neurotic mechanisms—the appeal for sympathy, such as he used to get from his mother, and aggressive attack, as had been used by his father—Al went into a panic. He telephoned the analyst and told him that he was terminating his therapy in the group and that he was going to commit suicide. At this crisis in Al's life several private sessions were scheduled in close succession.

Al's running away from the group at this time had some of the aspects of an adolescent rebellion against the family. He never brought his love for Ivy up in the group, so that it was not analyzed there, but he did talk to two of the members outside and was not able to secure their approval.

In the private sessions scheduled following Al's suicidal threat, the analyst told Al that he had been using his neurotic demand for sympathy and pity in an attempt to win Ivy, who was already committed and therefore unattainable. Following this, he had tried to gain the same end by aggressive at-

tack, also used neurotically, without any consideration for Ivy's wishes. It was pointed out that when both attempts had failed, Al felt that his only recourse was suicide, but that actually there were other alternatives. Al responded to this by saying that if he could develop the courage to commit suicide, as he was trying to do, this would prove that he was a man. The analyst suggested that this would by no means prove that he was a man, but on the contrary it would demonstrate the reverse, since it would be an attempt to avoid a real solution to a problem which seemed to him insoluble, namely, the problem of isolation and its solution through love. It was further suggested that a real solution would be to use his abilities to win a girl who was available.

The analyst told Al that the way he had behaved toward Ivy was not really the expression of love, since he had not taken Ivy's feelings into account. It did show, however, that he was able to form a strong attachment and was capable of deep feelings. He was urged to try again, in a more mature fashion, with an available girl, taking her feelings into account. The analyst expressed confidence that Al could have a much more satisfactory relationship with such a girl.

During one of the sessions Al showed the analyst some free verse he had written in moments of distress. It was original, sensitive, and moving. The analyst stated directly and with conviction that Al was greatly gifted and that if he did commit suicide this would be a waste of a fine talent. Thus, the approach was direct, warm, understanding, and realistic. The attempt was not to maintain classical aloofness, but, on the contrary, to participate with the patient in a deep dramatic crisis. To the analyst the ex-

perience was like jumping into the water and helping a drowning man to swim. Al experienced this interest and concern of the analyst, this type of close relationship, as the kind he had always wanted from his father, but never had. At the same time, the analyst expressed his belief in Al's capabilities.

With this direct approach, Al's depression lessened. He gradually became interested in other girls, and after a series of experimental adolescent love affairs in which, through continued analysis he learned that love is not license and that it does not involve ownership, he eventually met a girl who was both attractive to him and available, to whom he became engaged. At this stage he returned again to the group, where he received consensual validation of his progress from his peers and from the analyst.

An additional factor of importance in Al's analytical work was the analysis of his feelings of hostility. The marked intensity of Al's hostility prior to analysis is illustrated by the fact that on one occasion, when a subordinate contradicted him, he lost control and almost strangled him. Yet in spite of the intensity of Al's repressed anger he was largely unaware of it.

When Al first began to take part in the group, he would frequently glare at another member and yell angrily at him. When this was called to his attention by several of the group members, Al would say, "Was I yelling? I didn't know it." Al recalled that he used to try to get through to his father by yelling, a behavior pattern which had been established by his father's refusal to listen to him. Al's yelling in the group was an acting out of this original response. This was pointed out to him.

A further evidence of the depth of Al's reservoir of unconscious anger was

the degree of his ambivalence toward authority figures. His was not an out-and-out revolt, nor complete fear. It was a childish need to placate and an expectation of being rejected, the component of anger being repressed.

This is illustrated by the resistance Al exhibited to writing letters to administrative executives when looking for a job during the course of therapy. It was only after this was analyzed and found to be a carry-over of his fear of being rejected and criticized by his father that he was able to write these letters. Then he experienced feelings of improved self-esteem, but when he learned that other applicants were also being considered, he was sure that he would not be accepted and became depressed. It was pointed out by one of the group members that this fear resembled his feeling of inferiority toward his brother, a feeling which had been implanted in him repeatedly by his father. It was also pointed out that there was no rational reason for his continuing to feel this way.

To his surprise, Al was successful in securing a job in the field of his choice. Through continued analysis he gained insights which enabled him to see his employer as an individual, to observe that he was in fact friendly, and that he was accepted by him. As Al became aware of the fact that he could be accepted by authority figures, and as his consciousness of his own capabilities increased, his need to derogate his subordinates disappeared.

In summary, during therapy, which lasted three and a half years, Al's self-image had changed from a negative to a more positive one. He had given up his dependence upon his parents' distorted appraisals of him, and with the help of insight and increased awareness had incorporated and developed a

new and positive set of appraisals. Finally, he had validated this new concept of himself by direct action to secure satisfaction of his current needs.

My purpose in presenting this case has not been to give a verbatim report of the group interaction, which was frequently dramatic and intense. The purpose has been to select from the sessions material related specifically to Al, which was particularly significant in causing the changes that occurred during his therapy, and by condensing it to show the principal dynamic factors.

The process used was group psychoanalysis in the sense that the well-known principles of psychoanalysis used in individual analytic work were applied in the group.

#### THERAPEUTIC METHODS

##### *The Immediacy of the Relationship between the Analyst and Patient*

An important aspect of the therapeutic process in both the group and individual analytic sessions was the direct and immediate, experiential and personal relationship between the analyst and the group members, the group members among themselves, and between the analyst and the individual patient in the individual sessions. This is well illustrated by the treatment of Al during his period of suicidal crisis. The analyst did not remain aloof. He was entirely available. He tried to see Al completely, without reservation and without distortion, psychologically to get inside of Al and experience Al. This complete experiencing of Al as Al, as himself (so far as this is possible), was exactly the opposite of the way he was treated by his father, who never saw Al as he was, but only as an object to be used, exploited, and derogated. The

analyst, upon seeing Al in the sense described above, communicated to Al his exact feelings, without reservation. This constituted a new experience for Al. It is believed that by this type of experiencing of the patient and its communication to the patient, the patient comes to see himself in a new light, feels a new sense of self, and of personal dignity. Through the analyst's absorption in him he experiences a new sense of worth.

When the analyst functions in this way, the patient, by a kind of empathic linkage, is encouraged to react in this fashion toward the analyst and to experience the analyst and himself more completely, thus developing a more adequate sense of self.

The importance in therapy of this direct approach, this nondefensive experiencing of the patient, simply and without hesitation or resistance, is stressed by Eric Fromm.<sup>2</sup> According to Rollo May<sup>3</sup> one finds a somewhat similar view in the teachings of the Existentialists. Clara Thompson<sup>4</sup> emphasized the importance of the analyst being natural and spontaneous, saying that this, in turn, makes it possible for the patient to react more genuinely. Crowley<sup>5</sup> stresses the value of using such appropriate, unexaggerated, non-defensive and non-anxious reactions of analyst to patient to further the analytic work.

##### *Modification of the Derogatory Self-Dynamism*

The sense of the adequacy of self and the acceptance of self, which is essentially what Al developed during the course of therapy, is something that does not occur by chance. It occurs for certain reasons. When it is not present, the cause of its absence can be

reasonably clearly defined, as can the cause for its presence in those fortunate persons who have it. To use the case of Al as an example, Al had come to feel that he was "stupid and weak" because, while he was growing up, he was told by his father that he actually was stupid and weak, and this was not contradicted by his mother. Imagine this kind of derogation multiplied a thousand-fold, and associated with a cold indifference. In Al this was the kind of stuff from which the self (as based upon reflected appraisals) was made.

I should like at this point to quote Sullivan's basic formulation for the development of the sense of self. "The self may be said to be made up of reflected appraisals. If these were chiefly derogatory—if the self-dynamism is made up of experience which is chiefly derogatory, then the self-dynamism will itself be derogatory. It will facilitate hostile, disparaging appraisals of other people and will entertain disparaging and hostile appraisals of itself."<sup>6</sup> This was the case with Al. Sullivan's concept of the origin of the self was recently evaluated by Clara Thompson.<sup>7</sup>

Two additional points are important in understanding the therapeutic mechanisms responsible for modifying Al's derogatory self-dynamism. The first of these has to do with the fact that Al, prior to therapy, was not aware of the positive, creative, and likeable aspects of his personality. These were dissociated from his awareness because (according to Sullivan's concept) they were not approved by his parents or other significant persons in his infancy and childhood. Modification of his derogatory sense of self required that Al become aware of these positive, creative, and likeable aspects of his personality. Although they actually ex-

isted and were expressed by Al daily, their expression was not noticed by him. For example, when working for his Master's degree, he wrote a paper that was commended by his teacher. This did not make him realize that he had the ability to write a good paper. He merely concluded that for some reason the teacher was not telling him the truth. By this distortion he was able to defend himself against awareness of a good quality in himself and continue its dissociation. This left Al on what he considered to be the most comfortable horn of his dilemma, namely, that father was right in saying that he, Al, was stupid. This and other similar distortions were pointed out to Al.

#### *Undermining the Myth of Inevitable Parental Correctness*

The preceding discussion illustrates the well-known manner in which the neurotic reacts to positive appraisals of himself by other persons. He defends himself against awareness of their validity by thinking that the other person does not really understand him, is just being kind, is trying to get something for himself, and so forth. In order to undercut the patient's belief in the validity of such distortions—in this case Al's belief that the teacher was wrong and that he, Al, was really stupid—the analyst must help the patient discover by whatever valid means are at his disposal that the original significant adults were wrong in their derogatory appraisals. Using the material given to him by the patient he must show that these derogatory appraisals were the acting out of neurotic mechanisms by the parents and were not due to qualities in the patient himself. With this key, the patient is able to see for the first time that he does not have to con-

tinue to believe that his parents were inevitably right in their negative appraisals of him, and he is then able to unlock the door to a new review of his positive abilities. For such interpretations by the analyst to be successful, they obviously require a delicate sense of timing, a high regard for the actual facts, and working through.

*Analyzing the Stereotypes: Parataxic Distortions*

The second point referred to above concerns the reason why the negative self-dynamism, once established, continues to persist. This has been partially answered by the preceding example, which showed that Al so structured his experience that it agreed with his negative self-dynamism. Sullivan describes this as follows. "The stabilizing influence of past experience is due to the fact that when it is incorporated in the organization of the self, the structure of the self dynamism precludes the experience of anything corrective, anything that would be strikingly different."<sup>8</sup> I would like to state this same thing in another way, to particularize it, or objectify it. As an infant and child, and while he was growing up, Al learned to expect derogation from his father. By repetition over a period of years this became ingrained. It was learned and over-learned; it became a stereotype. The Gestalt psychologists, according to Hilgard,<sup>9</sup> have pointed out that once a habit is over-learned it prevents new and different experience from being seen in its correct light; the new experience is felt to be the same as that which caused the stereotype.

This is exactly what happened to Al. Having over-learned his father's responses and made a stereotype of them, he could not see others as they were,

but only as his father was. Therefore, when his teacher said that he had written a good paper, Al did not believe this, because it was not what his father would have said. Freud called this basic phenomenon transference; Sullivan called it parataxic distortion. Its continued repetition, day in and day out, is responsible for the unchanging aspect of the self-dynamism. What father said is not forgotten, because it is relived every day. There is no chance for it to decay through disuse. As described by Wolstein,<sup>10</sup> newly encountered people become participants in the perpetuation of irrational reactions.

In order for Al to be released from the effect of his negative self-dynamism and become aware of his positive abilities, it was necessary for him to see not only that his father was inaccurate in his original appraisals, but that he, Al, was perpetuating his belief in his father's negative appraisals by actually seeing and reacting to other people as if they were his father. It was pointed out that his motive for doing this was two-fold: to protect his own negative self-concept, which was the only self of which he was fully aware, and to secure his father's approval, so far as this was possible, by catering to his need to dominate through derogation. By reacting to other people in this way he attempted to avoid the risk of another rejection, but it was pointed out that this was unrealistic. With such interpretations the rigidity of Al's self-system decreased. In order to facilitate his seeing people in a new way he was urged to study them, to attempt to see them as they are, to look for the expression in their eyes, to allow his senses to register them without resistance. This approach, which the analyst had attempted to exemplify by his own behavior throughout the analysis, was

used at such times to focus Al's attention upon objective reality, and to help him try to experience it as it is, in contrast to what he had come to expect from his relationship with his father.

Thompson<sup>11</sup> states that searching out the origins of such irrational reactions and learning what the patient is unconsciously striving to achieve by them leads to their modification and disappearance through insight, and this proved to be true in Al's case. Horney<sup>12</sup> emphasizes the importance in therapy of helping the patient to change the way he experiences other people, saying that when this occurs constructive forces, such as the wish to develop one's real potentialities, become free to express themselves. Becker<sup>13</sup> points out the beneficial effect this has in releasing the patient to undergo further personality growth.

#### *Ways of Bringing Healthy but Dissociated Aspects of the Self into Awareness*

As the rigidity of Al's derogatory self-concept decreased, he was encouraged to look for and try to see positive aspects of his own personality. His attention was focused upon these not by exhortation, but by demonstration of the actual fact. To cite an example discussed above, the analyst listened carefully while Al read him the free verse that he had written, and then commented with interest and warmth upon its excellence and the sensitive and dramatic manner in which it had been read. Approval was expressed not only verbally, but with an expression of the eyes, a nod, and a smile. Then the analyst read the verse back to Al, so that he could listen to it and evaluate it more objectively. Al lay back, his eyes closed, attentive. After the analyst had

finished, Al opened his eyes, looked at the analyst and smiled. "I have to agree with you," he said. "It does sound good. I didn't think it did." Al had become aware that his ability to write was a creative power within himself, not an accident. This is an example of a reflected appraisal which Al incorporated. As is obvious, it was the end point of a long process.

#### *Giving the Patient a New Experience*

The present writer agrees with Eric Fromm<sup>14</sup> that an important part of the therapeutic process is giving to the patient a new experience. The analyst attempted to do this throughout the analysis by a directness and candor that was new to Al.

The protected atmosphere of the analytic situation is in itself a new experience for the patient and, as pointed out by Clara Thompson,<sup>15</sup> has important consequences for this reason. She states that when the patient finds himself in a less-threatening environment than he had previously experienced, hitherto undeveloped potentialities are discovered and encouraged, resulting in a constructive expansion of the self. Her statement that this is associated with a weakening in the rigidity of the self-system is supported by the present observations. Clara Thompson<sup>16</sup> states in her book, *Psychoanalysis: Evolution and Development*, that Ferenczi emphasized that it was the difference between the analytic experience and the patient's past life experience that made it therapeutically effective. This is reaffirmed by Janet Rioch<sup>17</sup> who says that only if the analyst supplies a genuinely new frame of reference can the patient discover the repressed elements of his personality.

*Participating with the Patient in Crisis:  
The Reverse of Classical Aloofness*

The writer concurs with Eric Fromm<sup>18</sup> that when the situation demands it the analyst should abandon his position at the side of the figurative swimming pool, jump into the water, and help the patient to swim. With Al this occurred at the time of his suicidal crisis.

*Essentials for Successful Group  
Analysis*

The preceding therapeutic methods apply in various degrees to group as well as to individual therapy. The following remarks will be directed specifically to the group process. It was found that certain factors had to be present for Al (and for other patients) to make constructive use of the analytic therapy.

1) As indicated by Florence Powdermaker,<sup>19</sup> the first of these was the freedom to re-enact with impunity his neurotic behavior in the interpersonal situation in the group.

2) Essential to this is the leadership of a non-authoritarian analyst who interprets the neurotic behavior and toward whom the patient feels he can look for protection if he should be attacked by the group. The fear with which many patients enter group therapy is well known, as is their expectation of being attacked by the other members. The analyst meets this childish need for protection by pointing out and analyzing the reasons why a patient who is attacked has precipitated such an attack, or by analyzing the neurotic hostility of the aggressor. This is done with warmth, with respect for the patient's integrity, and with acceptance of him as a person. The impor-

tance of these qualities in tapping the constructive forces of each individual during the group therapeutic process has been pointed out by Rose.<sup>20</sup>

Reference was made above to the importance of the protective atmosphere of the analytic situation. It is stressed again here because of the particular dependence of many patients upon the analyst during the early stages of group therapy.

*Unique Contributions of Group and  
Individual Therapy to the Analytic  
Process*

The philosophy and methodology of group analysis have been discussed by Kelman,<sup>21</sup> Wolf,<sup>22</sup> Rose,<sup>23, 24</sup> Powdermaker,<sup>25</sup> Wassel<sup>26</sup> and others.

*Group Therapy*

Group analytic therapy differs from individual analytic therapy in a number of ways. These all depend upon the fact that several persons participate simultaneously in the analytic process.

1. In Al's case, group therapy helped to make up for his deficit in juvenile gang experience by supplying a group in which he became a member. This experience differed from membership in a non-therapeutic group, since in such groups his resistance to participation would not have been analyzed. The analysis of Al's defenses against participation made possible a new type of relatedness to his peers.

2. The presence of other group members stimulated Al to multiple and diverse transference reactions, which were then analyzed immediately. The same result is accomplished in individual therapy by analyzing the patient's transference reactions toward the analyst. The difference in group

therapy is the diversity of the reactions produced in the patient by the other group members.

3. At times Al was able to accept an interpretation more readily from a peer than he was from the analyst, whom he often saw as an authority figure. For example, on one occasion he was extremely defensive about accepting the analyst's interpretation that the anger he felt toward the analyst was similar to that he had described feeling toward his father, saying that the analyst's behavior justified his present anger. He was more able to accept this interpretation when several of his peers in the group said they observed a close similarity.

4. Al observed early in his group experience that his own problems were similar in many ways to those of the other members of the group. In this way he learned by direct experience that his problems were not unique. This decreased his sense of isolation in a way that was not available in individual analysis.

5. The sheer weight of concentrated group opinion helped Al many times to break through a defense. For example, he often refused to recognize that he had reacted with hostility toward another patient, even though this was pointed out by the analyst. He saw it more readily when confronted by the spontaneous and concerted opinion of the group.

6. When Al acted out his neurotic pattern of behavior upon other group members, it could frequently be called to his awareness more readily than when he acted it out on the analyst alone. For instance, when at various times he tried to win the analyst's approval, he had strong resistances to recognizing the neurotic elements of his behavior because he saw the ana-

lyst as a parental figure. When he reacted toward the other group members in the same way, this pattern became more obvious to him; he could not so easily rationalize this kind of inappropriate behavior toward his peers.

7. A further, unique quality of the group important in Al's therapy was the effect upon him of the growth or regression of other members. These effects were varied. For example, the movement of other patients in the direction of health often stimulated him to a dissatisfaction with his present behavior and to a more intense desire to change his own neurotic patterns. Hence, at times it served as a positive incentive. At other times the expression of discouragement by another patient drove him to deeper feelings of inadequacy, which were then picked up and analyzed.

8. It might be said at this point that the group process makes possible a modification in the role of the analyst as a participant observer. In the group the analyst is able at times to be more of an observer and less of a participant. Although he is continuously the center of transference reactions from the group members, he is in a position to observe the acting out of the intense transference reactions of the group members upon each other with a slightly different perspective than when he is directly involved.

### *Individual Therapy*

1. The unique qualities of individual therapy depend upon one self-evident fact, namely, that there are only two people engaged in the analytic process. In consequence, the analyst is able to give to the patient his individual and continuous attention in a way that is not possible during group ther-

apy. In the private sessions with Al, the analyst was able uninterruptedly to pursue with him, step by step, the meandering ramifications of an association or an entire pattern of behavior to its origin, and demonstrate its current meaning by interpretation. This could not be done so easily in the group because of interruptions by group members. Its value is obvious.

2. In the individual analytic situation there was a complete directness in the meeting between Al and the analyst which was diluted when the analyst was treating a number of other patients simultaneously.

3. As demonstrated in Al's case, intensive individual analytic work is frequently a necessity in times of crisis, when the pressure of the neurotic mechanism is too great to be handled in the group.

4. With Al, as with other patients, some individual analytic work was required before he was introduced into the group. During these initial sessions the therapist discussed with him his life history and evaluated his neurotic mechanisms. During this process he formed a bond with the therapist which was important in helping him become a part of the group.

It is of course obvious that psychoanalytic group therapy is an application of the principles established through individual psychoanalytic research and practice.

#### DEPRIVATION OF BASIC EMOTIONAL NEEDS

Any discussion of the effect of deprivation upon the development of personality must, for clarity, begin with a definition of the various types of needs that are essential to the healthy growth and development of

the individual. Such needs, for the purposes of this paper, may be divided into two large classes: basic physical needs and basic emotional needs. A basic physical need is any urge or need which must be satisfied if the individual is to survive physically. Examples of such needs are for food, oxygen, and water. A basic emotional need is any urge or need which must be satisfied if the organism is to develop and maintain adequate mental health. Such needs are the need to be loved, the need to love, the need to be with others, the need for relatedness, the need to communicate, the need for respect, for tolerance, for trust and for warmth, and the need for tactile and kinesthetic stimulation. Such needs have been listed and their importance stressed by Sullivan,<sup>27</sup> Horney,<sup>28</sup> Montagu,<sup>29</sup> Fromm,<sup>30</sup> Maslow,<sup>31</sup> Bowlby<sup>32</sup> and others. In addition, as previously described, there are a series of specific needs that emerge as the individual develops.

It is with the effect of deprivation of basic emotional needs that the present paper is concerned. The literature dealing with deprivation of such needs has been reviewed by Bowlby<sup>33</sup> and Montagu.<sup>34</sup>

Deprivation of such basic emotional needs is illustrated most clearly by children who have spent their infancy and childhood in institutions, and who consequently have been deprived of the maternal love and care which every child needs. As pointed out by Bowlby,<sup>35</sup> of special interest is the work of Levy, Powdermaker et al., Lowrey, Bender, and Goldfarb. Referring to these studies, Bowlby says each investigator emphasized that the child's inability to make relationships was the central feature from which all the disturbances sprang. There was uniform

agreement that the principal cause was deprivation of maternal love, care, fondling, all of those things that a mother does who delights in her child and in whom the child delights.

The ill effects of deprivation vary with its degree. Complete deprivation, as shown by the work of Spitz<sup>36</sup> may entirely cripple the capacity to make new relationships. As pointed out by Bowlby,<sup>37</sup> partial deprivation produces anxiety, excessive need for love, powerful feelings of revenge, and, arising from these last, guilt and depression. All of these characteristics were present to some degree in Al at the time he began therapy. His case shows the effect of partial deprivation.

The pathological effect of deprivation upon the psychological development of the infant and child is demonstrated in the papers mentioned above. For the most part, however, the effects of such deprivation were not traced beyond the childhood epoch.

#### *The Effects of Early Deprivation upon Subsequent Personality Development*

I would like now to trace the effects of deprivation combined with parental acting out in Al's infancy and childhood upon personality development in subsequent stages of growth, namely, in the juvenile epoch, preadolescence and adolescence.

Al did not receive adequate maternal affection during infancy and childhood. His mother over-indulged him and was unable to protect him from his father's derogation. His reaction was to feel that he was not acceptable as a person. As a result he was not able to think of himself as being equal to his peers during his juvenile epoch. He expected from them the same kind of derogation he had received from his

father and remained aloof and withdrawn. At the same time he wanted from them the kind of pity his mother had given him. Not receiving this, he felt frustrated and withdrew farther.

Consequently, Al was not able to become a part of a juvenile group and he therefore was deprived of the satisfaction of the basic emotional need that emerges during this period, the sharing of experiences with peers and the beginning of the evaluation of his home as a socializing influence.

Therefore, Al reached the chronological age of preadolescence, the next stage, without having learned to share experiences with peers. The new basic emotional need of preadolescence is for personal intimacy and its satisfaction through friendship with a chum. This cannot occur adequately without previous experience in sharing. This Al did not have.

It was therefore to be expected that Al would not form any chum relationship in preadolescence. But the kind of intimate sharing that one experiences with a chum and the kind of friendship that one develops for a chum is a preparation for the next stage of development, namely, an intimate relationship with a person of the opposite sex in adolescence.

Not having had such preparation, Al was afraid of girls and remained aloof from them. Therefore, he did not experience in adolescence an intimate relationship with a girl, which is the basic emotional need of this epoch.

As illustrated by Al's case, whenever a basic emotional need is left unfulfilled a psychological pressure for fulfillment occurs and persists. The earlier and more severe the deprivation (within limits), the greater the pressure. A particularly damaging effect of deprivation in the deep dependency

needs of infancy and childhood is that the individual's drive becomes centered upon securing satisfaction of such needs at a later and inappropriate epoch. This leads to the development of a person who is neither fully capable of making decisions independently nor of securing satisfactions which require active participation. This occurs largely at an unconscious level, the infantile dependency need seeming to the person to be the one which should logically be satisfied and which would give him the most security. Such was the case with Al. The continuance of such infantile dependency needs was an important reason why Al was unable to develop satisfactorily through the subsequent epochs. The self-system did not change largely because the goal remained an infantile one.

Since one of the important factors in the etiology of the neuroses is deprivation of basic emotional needs, and since satisfaction of such needs is essential for mental health, the manner and extent to which such needs can be satisfied in the patient's current life constitutes one of the important therapeutic problems.

Numerous examples have been given to show how many of Al's basic emotional needs were satisfied—or at least partially satisfied—in therapy. For example, the members of the group frequently responded to him with affection. The group members and the therapist listened to him attentively, in a way which was new to him. The manner in which the group and the therapist reacted to Al's productions showed that they felt he was a person of importance. The therapist's response to Al, as for example when he threatened to commit suicide, indicated a real concern for him and a faith in his actual abilities. Al's group experience helped

to make up for his absence of gang experience during the juvenile epoch. He learned how to share intimate feelings with his peers in the group and also with the analyst, and at times to express tenderness and affection for other group members. This is exactly the kind of thing he had never been able to do with a chum in preadolescence, or a girl during adolescence.

As the result of the continued repetition of such experiences over a period of months and years, coupled with the analysis of his resistances, Al's self-concept began to change in the direction of increased self-esteem. As he felt better about himself, he began to secure satisfaction of his needs outside of the group on his own initiative, for example, in having adolescent-like experiences with girls, which finally culminated in his engagement to one.

While Al was undergoing these new experiences in therapy he put up very strong defenses. He originally developed these in response to the neurotic manner in which he had been treated by his parents. During the analysis of Al's distortions, he developed insights which enabled him to see his parents, himself, and others in their true light. Such analysis was essential to his being able to use the therapeutic experience (initially) and outside experiences (subsequently) to fulfill his basic emotional needs. When this occurred Al underwent a process of personality growth similar to that which takes place normally when a child develops into an emotionally mature adult. It would be inaccurate to say that Al repeated stages in growth that he had missed, since an experience missed can never be exactly duplicated. Nevertheless, many of the basic processes that occurred during Al's development in therapy were similar to those which

occur normally in the juvenile, pre-adolescent, and adolescent epochs.

# SUMMARY

The present studies indicate that the pathological deviations in personality growth which ultimately lead to the development of the neuroses are caused principally by early deprivation of basic emotional needs, combined with the acting out by parents or significant others, of their own neurotic patterns of behavior upon the child.

Such deviations, once begun in infancy and childhood, persist and cause further pathological modifications in subsequent epochs.

The correction of such deviations and the redirection of the patient toward a healthy and adjusted maturity occur in therapy as the result of insights into the motivations of his past and present behavior, the incorporation of a new and valid set of reflected appraisals, and a new type of interpersonal relatedness.

This leads to a reevaluation of the patient's self-concept and the realistic assessment of his actual abilities. He is then able to secure from his present environment satisfaction of his current needs, and with this the psychological pressure of infantile and childish goals diminishes or disappears.

As this occurs, the patient undergoes an abbreviated process of personality development which resembles in many ways the one which takes place normally during the juvenile, preadolescent, and adolescent epochs.

The manner in which this takes place during the analytic process is described in detail, and the particular contribution of individual and of group psychoanalysis is evaluated.

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34. Cf. 29, above.
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36. Spitz, René: *The Role of Ecological Factors in Emotional Development*, Child Development, 20, 145, 1949.
37. Cf. 32, above.

## DISCUSSION

Sidney Rose, M.D., New York: Dr. Abell has undertaken a most difficult task. He has presented a brief description of personality development and its practical application to the treatment of one patient in individual and group analysis. We are greatly indebted to him, since it is only by such reports, which correlate theory and practice, that we can arrive at a better understanding of what we do in therapy.

Although much therapy is being carried on, there are few reports of this nature. One reason is that such reports tend to be "unscientific"—which they have to be because of the nature of the task. Because of this they can be easily criticized. One can always question the depth and permanency of any improvement and whether it would have happened anyway in the normal course of events. From personal communication with Dr. Abell in which I learned more than it was possible for him to relate here, I am convinced that his patient, Al, had a deep growth experience with character change. However, as always, the crucial questions remain: What is effective in therapy and how? What is a growth experience?

Dr. Abell has given some concepts he found helpful. Do not for a moment think that he intended to convey the notion that the vastness, complexity, and concreteness of the therapeutic process can be con-

tained in a few formulations. Completeness is never possible and each of us focuses on those constructs with which we are most familiar. Ideally speaking, we should be in constant search for those tools enabling us to conduct therapy with the least waste motion and optimum results.

It is important not to take theoretical concepts too literally. When theoretical abstractions are used as categories, the description of one patient begins to sound like another and everyone will feel that this applies to him. Every neurotic has been deprived in some way, has hostility, derogates himself, and has sex problems.

Dr. Abell briefly describes stages of development, in each of which certain emotional needs required fulfillment. Any pathology caused by the failure to satisfy emotional needs at one stage impairs the next stage of development and there is no way of making up for the deficit in later life. While Dr. Abell makes a strong point of this, he does at times imply that the group supplies the individual with the satisfaction of emotional needs lacking in childhood, particularly adolescence.

Dr. Abell makes a straight-line connection between neurotic facets as they emerge in the analytical process with events that occurred in childhood. For example, he refers to the aggressiveness of Al as an identification with his father's aggressive-

ness. Al's sympathy seeking role is a repetition of the role he was encouraged to play by his mother's over-protection. Al's self-derogation is the internalization of his father's belittling attitude. In the group process especially, this approach seemed to work and, therefore, on an empirical basis, it has a degree of validity. To me the intrapsychic concepts of Horney are more helpful in understanding what goes on in the neurotic and his reactions in the group.

For example, I would not consider Al's self-derogation merely as an internalized appraisal from his father. What is important is the entire neurotic character structure and absence of a real self which perpetuates such a feeling. Furthermore, before the child is old enough to be aware of himself as an entity there is no self-derogation. The feeling that the child has can best be described as a feeling of aloneness and weakness in a world that is potentially hostile. This Karen Horney calls basic anxiety. By her over-protection, Al's mother contributed to this feeling by acting as if the world were dangerous. As the child grows, the mind and imagination develop and in the healthy child are used in an active, eager, curious search to understand and explore the world. Where there is much basic anxiety, with feelings of weakness, being threatened, and aloneness, the mind and imagination are deflected from their healthy function and construct an image of the self which can give the individual a feeling of great significance. By the use of this self-concept with its idealized and despised aspects, the various clusters of values can be expressed in abbreviated form. The idealized image, with the whole pride system, contains within it all the pathology of earlier stages.

With the pride system as the central concept, Al's self-derogation can be viewed in a new light as part of a complex process in the present. With self-derogation there are implied expansive needs. When he hates himself, the "he" as subject is overbearing and vindictive to the actual self. Also, feeling inferior means that he has to have something against which to measure himself in order to find himself lacking.

Al's idealized image is out of awareness, but it determines his conscious feelings of inadequacy and inferiority.

When the group encourages Al to participate in real life, he has as yet no real self with adequate cooperative behavior patterns. He can only venture forth with the expansive-aggressive side of his neurotic self. He is, therefore, bound to make excessive claims, so that his initial ventures into the world are doomed to failure. When he moves toward Ivy, Al has to gird his loins as he engages in what he experiences as a great challenge. That he is identifying with his father's aggressiveness is only a small part of the picture. The whole constellation of patterns comes into evidence as he engages with Ivy. He is the virile man who must succeed. Her non-acceptance of him is experienced as a crushing defeat to his grandiose self. All his self-hate is now activated. He also feels anger toward Dr. Abell and the group. They are responsible for pushing him into such a humiliating situation, but he needs them and is dependent on them and so must hide his hostility and turn it against himself. He has nothing but his self-hate, which seeks an outlet. By exaggerating his sufferings and threatening suicide he can accuse the group and Dr. Abell, and so in a surreptitious manner express his domination over them. At the same time he can win their sympathy and attention and not jeopardize his dependency. At this crucial stage he did receive considerable support. He remained in the situation without running out of the group. This enabled him to see that the degree of his failure was exaggerated.

Furthermore, as Al engages with Ivy they are not alone. Dr. Abell and the group are in the background and are influences. He has them as support and a foundation which stands him in good stead as he ventures forth and becomes involved in life.

I mention the above formulations to show how it is possible to connect the various neurotic aspects of Al's personality in a cross-section in the present, how his feelings of self-derogation are connected with the unconscious idealized image. As

he moves toward Ivy, he leads with his idealized self and claims, although these excessive claims are doomed to frustration and give rise to increasing self-hate. The self-hate and suffering are then used to stir up feelings of guilt and to reestablish connection with others by evoking sympathy. All this would have alienated him further from his real self if he had not been immersed in the analytical atmosphere of mutuality and acceptance. This was in the background all the time. Only these positive ways of relating can nourish the real self and sustain the individual through periods of disillusionment.

The way I formulate the process is not the only way. I have described events in a cross-section manner in the immediate present. Dr. Abell has looked at the process on an interpersonal level, connecting present neurotic facets with the past. Others with a different theoretical bias might package analytical events quite differently and sound just as convincing. Such theorizing provides paths into the great unknown of the psyche, and once embarked on such a path it is difficult to retrace one's steps or to see what others perceive from their vantage point.

How much real substance do these formulations have in actually helping the patient? They are important in diagnosis, prognosis, and patient selection for groups. They are helpful in giving the therapist a feeling of confidence and mastery which is so essential when dealing with frightened people. They help in conducting a group, but when it comes to giving interpretations their values are limited. An interpretation means that we point at something, implying that there is something wrong and irrational, as if common sense will then take over. Repeatedly we have to learn the importance of an openness to feeling and of deep emotional experiencing. Telling a patient about his assets is futile. A beautiful woman who feels she is ugly will not believe what the mirror tells her. The articulation of positive appraisals has minimal influence. The neurotic pride system is a barrier to their entrance. At the same time positive apprais-

als from others on a non-verbal level reach the individual more effectively.

The point I am belaboring here is that there is much more going on in therapy than insight into irrational behavior. Insights are the verbal, visible parts of a complex growth process. Dr. Abell has done much more than point out insights into the therapeutic process. The therapeutic effectiveness is much greater than is warranted by the interpretations and insights alone. For the purpose of group analysis one can question the value of intricate formulations of the personality makeup of each individual and their use for interpretations. They are helpful in recognizing irrational reactions, but such reactions can be identified without reference to their intrapsychic meaning. What the therapist must keep in the foreground is working toward a group atmosphere, with a feeling of oneness based on values inherent in the group therapy process, and toward its reestablishment when it has been threatened for too long a period. It is the group atmosphere of mutuality and acceptance that gave Al a new feeling for self which undermined his pride system. Even when not actively engaged in the group process the silent individual breathes a free atmosphere. Just as Al would feel defensive, threatened, and secretive when in the presence of his father, so in the presence of the group he could be open, relaxed, and willing to expose himself.

The group members have learned a new language, non-defensive, gratifying new ways of communicating. The most accurate theoretical knowledge will be useless in the creation and maintenance of such an atmosphere, unless it is integrated into the personality of a minimally neurotic therapist. All the skillful mastery of intricate theory can never replace deeply felt concern at the appropriate time. Al's improvement was made possible by Dr. Abell's dedication and devotion to his task. The appropriate atmosphere in groups can only be created if the analyst is very much the human being. For what therapy tries to accomplish is to enable people who feel sub- or superhuman to feel like human beings.

# COMMUNING AND RELATING

## PART III—EXAMPLES: GENERAL AND CLINICAL

HAROLD KELMAN

AS WESTERN man's relation to the magic world changed, so did his relation to nature and to his own nature. While few have been aware of this disconnection from the awe and dread of daily reality in its mystical immediacy, many have written about Western man's dissociation from his organicity, from his innate biological rhythms, from his nature and from nature in general. While this dissociation was going on, man made great efforts to struggle against its happening and affirmed in many ways that maintaining contact with nature, his nature, and a presence transcending his individuality, are positive goals and in accordance with his true nature.

There is much evidence of an awareness of communing, of the nature of communing, and of its assistance in struggling against dissociation and in furthering the maintenance and increase of man's contact with his nature, nature, and the all. Throughout time, in prose, poetry, painting or music, the scene of the shepherd and his flock have been endlessly depicted. Sometimes he is lying on his back asleep or gazing into the heavens. At other times he is singing or playing on his pipes. The scene represents and evokes the ultimate of communing with nature, animal nature,

human nature, and the nature of a presence greater than us all.

But to be present as part of such scenes is something more, and this has happened to me in various parts of the world, alone and with others. The response, when suddenly coming upon such scenes, is a catching of the breath, awe, silence, and being rooted to the spot. The usual sense of time and space disappears. Of this one becomes aware when one, so to speak, 'comes to'—i.e., returns to the conventional. The immediately preceding feelings remain and one resists feelings of moving away from them, or intrusions that might draw one away. From time to time in later years, such occasions will come to mind when I am "distracted." Yes, distracted from the conventional and open to the unconventional, the spontaneous. In the breath-catching and the being rooted, fear can be inferred, maybe dread.

### BEING SILENT, BEING QUIET, BEING STILL

In this instance, as in many that will follow, communing will be associated with silence, quiet, and stillness. Speaking in terms of the process of being silent, being quiet, and being still adds further dimensions of meaning. Human beings have been

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long aware that communing, being connected with the magic world, the world of nature and our nature, happens more often in silence and while being still. To attain this ultimate of outer and inner stillness, Jesus went into the mountains, Mohammed into the desert, and Buddha sat under the bo tree. The use of silence by individuals and groups has a long history,<sup>1</sup> whether for religious, ethical, or political purposes, or for self-development.<sup>2</sup> Laotzu spoke of 'creative quietism.'<sup>3</sup>

My personal feel of silence and being silent relates to the absence of vocalization. Note that I put it in a negative form because I am still too much attached to Western attitudes. Being silent can be a positive, affirmative form of communication and communicating communing. Although I have not been a part of it, I frequently have read of the depth of communicating and communing among American Indians. From our viewpoint they are silent people; from theirs, we are chatterboxes. There are numerous descriptions of the silent coming of an Indian to sit in front of another's tepee, seemingly not even seen or noticed while he sat there silent.

While being silent has the feel of non-vocalizing, being quiet feels to me like remaining in one spot, motionless, whether erect, sitting, on one's knees, squatting, sitting cross-legged in the lotus position, or being horizontal, supine or prone. Being quiet includes non-vocalization, and the cessation of all volitional motor activity. This means minimal distraction by skeletal volitional activity and slowing to minimal basal rates the smooth-muscle activities in breathing, heart action and bowel activity. With being silent and being quiet, being still becomes all the more possible. Because of our conventional ways of thinking, we speak of stillness and it sounds and feels like a thing, a state, something static but also something arrested and held in check. Being still actually can be a most active way of being, during which total listening, not just with the ears, becomes more possible. With such listening we begin to hear more our natural, spontaneous, organic rhythms and become more con-

nected with them. Concomitantly, there will be more moments of communing.

An instance of being still that happened in the summer of 1947, remains vividly with me. I have related it many times since. For years thereafter, some of my hearers have said spontaneously how moved they were by the telling. I vacationed that summer, as well as for four other summers and one winter, at Lake Atitlan in the highlands of Guatemala, the home of the Maya Indians. The village on the north shore where I lived was on a delta at the foot of mountains which rose almost precipitously to eight thousand feet. The village level was 4,500. On the south side of the lake, about six miles across, rose three extinct volcanoes, ten, twelve and fourteen thousand feet. I have never seen before or since a scene of such great natural beauty that presented something new every moment of the day and night and through the seasons.

Often I walked along the lake shore. I was sitting in an isolated spot on a log late one afternoon watching the brilliance of the setting sun behind the volcanoes. At that hour the lake surface was like glass and no one was on it. Not a leaf stirred. The only occasional sound, as external evidence of movement, was of a bird in flight. I do not know how long I had been sitting there when to my left, about fifty yards away, down a path, soundlessly, in their bare feet and in their native costume, came a father and his three-year-old son. They were holding hands. At the lake shore the father lifted the little boy into a boat and then got in beside him. They sat there motionless until it was almost dark. The father lifted the little boy out, took his hand, and walked up the path until they were lost to my view.

Throughout I heard not a sound, saw no expressions on the face of either indicating that they were talking to one another or had even turned to look at one another. How long they or I sat there, or how much time elapsed between my arrival and my return up the path to the village, I cannot say. By the clock it might have been sev-

eral hours. Feeling-wise it was a moment and eternity. The feeling of stillness and being still outside of myself and to a degree inside of myself was palpable, tangible, concrete. While it was going on there were feelings of awesomeness and wonder as well as of unease. Watching and being a part of this whole event, I felt as though I were intruding on a sacred rite. Maybe it was part of their religious practices, for rituals around the rising and the setting of the sun are common. And, in fact, at the base of the highest volcano is a small hill in which many archaeological treasures have been found. From ancient times the Indians have called it *Cerro de Oro*, hill of gold. Maybe I was part of a sacred rite, of a father being with a son in the ultimate of intimacy, which is communing.

For long periods in analysis a patient had been obstructively silent. While being so, I noted that he held his body rigidly quiet. When he could begin to speak, I could infer from his associations—and from what I learned later—that inside he felt quite stirred up and was trying by neurotic solutions to still this inner disturbance. Later in his analysis he was able to dare to be constructively silent. I noted that his body at first was relaxed and quiet; then he would become restless, ending with his body being held rigidly still and with breath-holding. He described what happened as “a going into myself.” Following it he had lots of feelings for which he could not find words. While it was going on, he felt no problems and no tensions. He described his state of being as “feeling good” and wanting to leave well enough alone. Such a feeling was contrary to his usual compulsive need to make more or less out of something, or freeze it forever and ever. Right after, he had a feeling that his head was expanding and he saw, fearfully, pictures of a vast expanse. He felt it was “like the beginning of a voyage into the unknown of myself. It must be like what a musician or an artist feels when he begins to write music or paint a picture.” As this man’s analysis proceeded, the frequency of letting go increased with more and more total body

involvement in the letting go. At the end of such episodes of “letting-go and grabbing,” which might go on for up to a half hour, he would inform me that he felt quieter, more relaxed, and healthier than ever before in his life. Moments of being silent, quiet, still and of communing were occurring more frequently.

These moments of being silent, being quiet, being still and of letting go occur not only in analysis, but, in fact, are not uncommon in the lives of many people. In the course of analysis, patients recall the occurrence of such episodes, or they are recalled by hearing someone relate similar experiences, or while reading about them. These incidents were related to me after lectures on the subject of communing. The first happened in an analytic session two days after one lecture; the second was related to me after a lecture by the person who had had the experience.

In the course of the session, the patient reported saying to her husband, in reference to her analyst, “I’m interested because she is my friend.”\* This comment was picked up, as was a subsequent one about courage. Following the latter the patient said, “I feel you are my friend in quietness. I can’t say exactly what makes me say that—but like there are always a lot of people around, talking, talking, talking, giving opinions, advice—I don’t know. Like I see you standing in front of me, quiet. They are in the shadows, but the sun shines on you. You are not saying anything, but somehow . . . although you are silent . . . I get a message. Many things you’ve said I’ve used as a crutch when the going was tough and I was so upset. Like I’ll ask myself what to do and a voice would answer, ‘Dr. B. said to live with it,’ or ‘She said that you have to take a first step.’ It has helped living with things, but not resolving conflict. But the work that we do that has enabled me to do more, and more freely . . . I can’t remember—I don’t remember things said. You said something to help me spill the beans—but I only know it happened. I

\* Personal communication from Dr. Helen W. Boigon.

only know there has been progress. All you said was something like, 'How come . . . ?' or 'What about . . . ?' or like that. To this there are no monuments. Only hidden treasure.

"To the degree it is humanly possible, you have . . . well, people are often so overbearing, like we just must exert our wills on others. But . . . I was saying . . . to the degree it is humanly possible, you haven't done this, and by not . . . something about acceptance . . . a feeling from you of greater acceptance of me.

"It's one thing to say our work here is to find me . . . the objective aim, yes. I think it's what you're trained to do. But you can't tell me you don't need more than that; I can't believe that this art and science can be only taught. You have to put something in it . . . and I feel you've applied what they taught. But like all the finishing touches . . . what counts . . . is what you are yourself."

Just before these associations, this patient mentioned "that a door has opened" and that all this had been going on in the context of more 'deeply experiencing conflict. Only as accepting is obtaining, first by the therapist, and then more and more by the patient, can the patient be more and more open and feel doors opening. For these things to happen there must be increasing ability to be silent, quiet and still. And in the process there must be pain, struggle, hanging on, despair, exhaustion, and finally letting go. Through many of these sequences we let go of—and thereby resolve—acquired patterns of being that have been blocking us from realizing our possibilities. Sometimes when a possibility becomes an actuality it is clear and definite as to the moment it happened—as in the following instance.

#### LETTING GO AND HANGING ON

"I can remember the exact moment when I learned to swim.\* I had been brought up near the water, but I found it very difficult to learn to swim. I would continuously

try, but after swimming a relatively short distance I would feel out of breath and unable to continue.

"When I was thirteen, I went to a Boy Scout camp. One of the prerequisites for being allowed to take out a rowboat was to be able to swim fifty yards. A short time after I came to camp, I attempted this. I must have swum about forty yards; then suddenly I felt myself unable to go any further. Before any assistance could be given me I went under. One of the men who had been following me in a rowboat had to jump in and help bring me ashore. I was very disappointed as a result of this experience.

"A few days later, another boy at the camp asked me if I could help him get ready to take his test in junior life saving. One part of the test consisted of his being able to demonstrate how he would rescue a person who was drowning. He asked me if I would simulate a drowning person, so he could practice various rescues. I agreed. I simulated drowning and he would catch me and swim back to the dock. After a number of times, I suddenly became aware that I was no longer fearful and was no longer getting tired, as I used to when I was in the water for any length of time. In that moment, it seems to me, I suddenly felt that I could swim.

"The next day I again took the fifty-yard test and completed it without any difficulty at all. A few days later I took a test to enable me to take out a canoe. Among other things, this entailed jumping into the water clothed, removing the clothing, and then swimming a distance of two hundred yards. I completed this without any difficulty. It seems that from that moment on I could swim any type of stroke in any position, without any difficulty at all."

The process prior to that moment is very clearly described: struggling with hanging on, while at the same time, trying to let go; exhaustion, fear and despair. The pattern is familiar. It is how Dr. S. learned to swim, or, more accurately, how he discovered he already could swim. In simulating drowning he was repetitively going

\* Personal communication from Dr. Robert L. Sharoff.

through the experience of letting go. It was not only all right and safe to let go, it was required of him. And all of a sudden, as he puts it, "I was no longer fearful and was no longer getting tired." I would put it that he was no longer afraid to let go, and hence was no longer exhausting himself by hanging on and letting go at the same time and thereby disturbing his breathing rhythm. From my discussions of the creative process, of creative and clinical insight, and satori, we already are familiar with the suddenness of becoming aware. In all of them the suddenness of seeing was described in many ways.

Moments of letting go will not always be experienced as something constructive. As a person is getting sicker and more rigid, he will experience it as a frightening loss of control; he will feel dizzy, have a sense of dysequilibrium, be nauseated, and often will panic. Just this happened in the early months of the therapy of a very sick and precariously held-together young woman, except that she experienced what happened as being suddenly and mysteriously overwhelmed. This had occurred not only because of the precariousness of her defense system, but because of a unique set of circumstances. She brought up—and I helped her go into and thereby threaten in a very short time—a number of fundamental neurotic patterns. She was so taken off guard and so many things happened at once that she couldn't possibly have brought her defenses into operation, and even if she had attempted to do so she would have failed. By contrast, three months later she quickly sensed the beginning of such an experience (as I shall describe shortly) and immediately became cautious and dropped the subject of her needs for privacy and her feeling of being tremendously threatened when her privacy was invaded.

The first experience occurred as we were talking of her fears of fainting in public places. These included her own drawing room, with friends in attendance. Her fear was not only "of being gaped at" while unconscious, but also of the painful and intense discomfort she suffered whenever

she was the center of attention. We had been going into the history of these fears. When I asked if she had had in her childhood some private places which only she knew and which she felt as her very own, she looked surprised, and answered that there had been two. About the first she never told anyone. On two occasions she took her very best little girl friend to the second one, which was not quite so sacred.

A few minutes after telling me this she began to look frightened and to become quite restless. She felt "queer": "I have an upset stomach," "feel nauseated," "dizzy." Frantically, she kept repeating that she was "going to faint" and "to keel over." She felt "weak" and "drained." I suggested that she lie down on the couch which she did very reluctantly, remaining there for only five minutes. Although lying in a curled-up, foetal position, she looked as though any minute she would jump up and run. In fact, she did so as soon as she could, and sat in the chair opposite me. With a worried, anxious look, she talked about the experience and kept repeating frantically, "I don't understand. I don't understand it. It has never happened to me before." After some minutes she left the office.

Several hours later, at home, she went into a panic and phoned me, crying and in terror. After about twenty minutes, during which she did most of the talking, she quieted down. In her next session, she upbraided me violently and blamed me for the experience. At the time I felt it might have been avoided had I been more alert and cautious. In subsequent months my feeling changed, particularly following the second such experience, which she handled without too much difficulty. My impression six months after the initial episode was that the gains more than outweighed the costs.

I will now continue with the attitudes toward letting go, of a patient who is getting sicker and fighting loss of control. Consciously and unconsciously he is directed toward hanging on rather than letting go. What he is trying to hang on to are his neurotic patterns, and he is attempting to build up more of them for purposes

of safety. These patterns he erroneously calls his individuality, when in fact they are his sick egocentricities. Such a person, therefore, constantly fears losing what he calls his individuality when threatened with feelings of letting go, in or outside of an analysis. In analysis such patients defensively attack the analyst with "you're trying to make me like everybody else, the same as everybody else. You're trying to make me mediocre, average, normal. You're trying to take my individuality away from me." Related to this are the sick fears that their so-called artistic temperament, their artistic sensitivity which is neurotic hypersensitivity, will be undermined by analysis. The fears, aversions, and even the strong antipathies some persons have toward certain aspects of Oriental philosophies might be similarly motivated. It often concerns the notion of merging with the all or becoming one with the all. The only aspect such people seem to be aware of is the letting go of, the losing something, aspect. Actually, it has been affirmed over and over again in endless religious, ethical, and psychological systems that only by losing yourself can you find yourself. Fundamentally, the fear comes from a lack of faith in human spontaneity and from not knowing that with a losing there will naturally follow a finding, with an emptying there will be a filling.

#### "LONELINESS" AND "THE DARK NIGHT OF THE SOUL"

Besides individual neurotic factors which contribute to such attitudes, there are cultural ones and those inherent in our language structure. We say, "I was alone" and "I was with others." We will allow, "I was by myself," but to say, "I was with myself" sounds awkward. How come it sounds awkward has many roots, one of them being that in this sentence we are confronted with the problems created by our subject/predicate sentences and our dualistic thinking. This sentence says there is a separate "I" and a separate "myself" with whom this separate I spent the week-end. Because of the cultural value put on gregariousness—now called other-directedness and con-

formity—spending a week-end with myself or by myself must mean going against the cultural mores and, of course, it is implied that one would not do that from choice. Therefore, one did not spend it with oneself through choice, but alone because one did not have friends with whom to spend it. It follows then that one was alone, lonely, and felt isolated. And automatically aloneness means painful feelings of loneliness and of being isolated and cut off from others.

In our culture it is difficult for people to see the compulsive nature of their gregariousness and their terror at being with themselves. Hence, it is also difficult for them to experience the possibilities for healthy being with oneself and thereby come to distinguish such feelings from unhealthy ones of aloneness, loneliness, and isolation. I have seen patients move from compulsive gregariousness to compulsive isolation and ultimately to a more harmonious balance of healthier being with others and with themselves. Likewise, I have seen the sequence of compulsive aloneness to compulsive gregariousness and also to a healthier balance of being with themselves and with others.

Persons who are compulsively gregarious and those who are compulsively alone will both experience fear of losing their individuality with letting go. The gregarious one feels he experiences his identity and separateness best in the company of others, while the "loner," as one of my patients referred to himself, felt smothered when with groups. He felt himself an identity and a separate, unique being best when alone. Actually, both are talking of sick feelings of egocentricity, neurotic uniqueness, and pseudo-identity. Only as they let go of these more and more will they become aware that only as one can be healthily with others and with oneself, can there be healthier individuality, healthier feeling of identity, healthier feeling of separateness and togetherness, and more and more moments of communing. In the last section of this paper I shall again take up the subject of separateness and togetherness and how patients experienced both as they were

becoming aware of them, concomitantly and in healthier ways.

Whether the compulsive pattern is that of aloneness or gregariousness, the individual will experience sick loneliness as he lets go of it. Technically, Horney referred to it as an aspect of basic anxiety which is characterized by the feeling of being alone and helpless in a potentially hostile world. It is the being alone aspect which is referred to as being lonely, being alone, or loneliness. This is a most painful feeling and people go to great lengths to avoid it, such as interrupting their analytic work as they begin to experience it in depth and extensity. There are many known and many unknown factors in the individual, in the analyst, in the environments of both, and in the world situation that might account for some patients being able to stay with, and remain open to, such painful feelings.

As they are more able to, they begin to be aware of other feeling which they experience as loneliness but which in time they recognize as different in quality and direction. It is the feeling of standing on one's own feet, going it alone, going into the unknown, the strange, the new. No one can be in anybody else's skin. Just as at some points we must leave our theories behind because they cannot serve as guides in this new territory, so it is with human help, after we have given the ultimate of human help possible in an analytic situation. We can go together with our patients a long way, but there also are boundaries of possibility to that help. Experiencing the way and the process is something only one's patients can feel. And only they can let go and leap into the unknown, and go the way of the dark night of the soul, alone and in fear, dread, and trembling. As they chance such experiencings more and more, they can clearly distinguish this feeling from sick loneliness. They also experience more and more faith in themselves. Though tentative, there are degrees of certainty with which we can mutually agree that analytic work can be continued in separateness and togetherness and with an inner wisdom. Whether and when to terminate

regular analytic work, how to continue self-analysis, and if and when to see each other again are no longer major issues. The feeling is more likely to be that as events mature things will happen.

#### MAINTAINING COMMUNING

Earlier I spoke of an awareness of communing, of ways of supporting possibilities for it through contact with our natural rhythms and those of nature. I have mentioned the significance of the shepherd scene. We know many examples of people communing with themselves through constant communing with nature in the profession of gardener or forester. Many others who do it as an avocation are aware how crucial it is in helping them to maintain their balance. The best some can do are short holidays in the midst of nature. Some maintain contact through professions associated with animals—horses, dogs or house pets. This maintaining of self as a whole and as unity while manifesting startling evidences of communing with plants and animals, where there was an inability or even terror of contact with humans, has been the basis of many novels. I speak of idiots, mutes, or persons seriously deformed in other ways, who literally seem to be able to "think" like plants and animals, and hence could do such fantastic things with them, fantastic by comparison with what an average, healthy individual could do.

This maintaining of the possibility of communing through profession or avocation can and does go on in most instances without conscious awareness, but through some deep inner wisdom. I have known nurses who were well aware that they felt happiest with infants and that it was unwise for them to take care of children beyond one year. Men and women have selected pediatrics as their speciality as an expression of such a deep awareness. I know of several doctors who turned to this speciality when they found out that their wives would be childless. Nurses and pediatricians maintain an immediate contact with life, with organic rhythms in young human beings before they become distorted through cultural convention and

disturbed human relationships and dissociated from natural organic spontaneity.

#### REGAINING AND REAWAKENING COMMUNING

In the course of one woman's analysis I became aware of a regaining and reawakening of a mother's capacity for communing with an infant, only in this instance it was of a grandmother with her four-months-old grandson. When she told me about the experience she was not aware of its significance, except that it was delightful and very meaningful to her. Painful recollections followed of her children's infancy, twenty-five years past, when she had been unable to commune with them.

In general, I feel communing is natural to all human beings. It functions in special ways with mother and infant unless, as with this woman, it had been blocked out by long years of physical and mental illness until reawakening during analysis. Some of the special ways communing obtains in the organic unity of mother and infant and child bear mentioning. Husbands often report being awakened during the night by their wives' getting out of bed to tend to the infant, although the next morning they have no recollection of having done so. A mother also may have got out of bed in response to some need of her infant without her husband having heard a sound from the crib. As for the child, once he begins to walk he may get out of bed, come into his parents' bed, be returned after a while, and have no realization of this behavior upon waking. I am not unaware of the possible somnambulistic aspects of the latter, but am referring to a much more common, transient, and less serious occurrence.

By the time this incident had occurred and was reported, the patient had become deeply acquainted with feelings of rhythmicity in all aspects of her being, including her natural organic rhythms, such as eating, defecating, urinating, sex, breathing, sleeping, and locomoting. I mention rhythmicity and, particularly, organic rhythms because of their immediate connectedness with communing, and also because this in-

stance has to do with an awareness of disturbed natural rhythms in her grandson and with its relief. Also it has to do with communing at the pre-verbal, sub-verbal, a-verbal, non-verbal level—or however you may wish to label it. Actually, any labelings containing the word verbal make little sense. The infant is far from making sense in verbalizations or conceptualizations. He makes sense, but on wordless levels whose nature we can only infer or conjecture. What I am saying is that we do not have adequate formulations to communicate what obtains in such instances, and that formulations do not adequately apply to this level of happening. Therefore, I feel by describing in detail what happened, more doors will be opened to responding, however you may.

From the grandson's birth, his grandmother had been with him frequently and had cared for him with much pleasure. His changing from day to day, and his developing, were an endless source of joy and curiosity to her. At the same time, she was poignantly aware of not having been part of this mutual process with her own children. She communed with the grandchild while being mutually silent, quiet, and still, while he was awake and asleep. She also communed with him by holding his gaze when he first began to follow her with his eyes. She mimicked his facial movements, sounds and gestures as he acquired and manifested them while being with and looking at her. There were also all the many aspects of communing that went with being held, fondled, fed, diapered, and bathed. One outstanding form of communing was through her making cooing sounds and singing to him in a quiet, gentle voice. As he grew older, rhythmic sounds, such as gurgles and music, meant very much to him in their intimacy.

It was in this evolving context that an incident occurred when he was about four months old. She was taking care of him one afternoon. She had fed him his bottle and had put him into his crib. He fell asleep shortly but awakened in about half an hour, screaming. In succession she examined his diaper to see if a pin was sticking him and whether he was wet or soiled,

and then she picked him up and patted him on the back to help him belch in case stomach gas might be causing him pain. Following each of these procedures she would put him down, following which he would again begin to scream. Up to this point there is nothing unusual in what she did. Each one of these actions she carried out slowly and gently, and only after having allowed him to scream for awhile to make sure it was something more than his usual exercising of his lungs, which he enjoyed doing from time to time.

Following her third attempt, she allowed him to scream a bit longer while constantly looking at him and making gentle cooing sounds. She then began slowly to rub his belly gently, without explaining why she did so, as she related this incident to me. As she did so he began to become quieter and as she stopped he would start screaming again. After several such interruptions, and while rubbing his stomach, she noted he began to look at her intently and she imitated his look. Then he began to strain and flush, which she did likewise. After a bit he passed a lot of flatus, following which his face became wreathed in smiles and again his grandmother repeated his facial expressions. Following his passing wind she stopped rubbing his stomach and he began to whimper. She again began to rub it. His face again began to become intent, then strain and flush, and he began to make grunting sounds, all of which his grandmother repeated. After a few minutes he passed a large hard stool following which his face again was wreathed in smiles. His grandmother cleaned and held him for awhile. After this she put him down and he fell soundly asleep until his evening bottle.

There is much in this incident of adult-infant communication—at least, communication as the adult experiences and formulates it. The adult may name it imitating the infant's gestures, expressions, and sounds. The label, non-verbal, as I said above, distorts a process in which verbalization and conceptualization have no part—certainly not for the infant. Examining him for pins or a soiled diaper, and burp-

ing possible gas bubbles are logical, familiar, and learned. But what dimensions of being moved the grandmother to rub his belly? For me it is best described by saying communing was obtaining. To have done just that and not a number of other things, and with just that being what was specifically helpful for that specific problem, may have been coincidence, but I feel it goes beyond that. Only where communing obtains, where oneness is experienced, where organicity of infant and adult is felt, where in Oriental terms the subject-other relationship obtains, could this sequence of events be more likely to occur. To add a clinical note, only after this woman had worked through her general remoteness from her natural biological rhythms, and acquired a pleasure in them, could this even have been possible. Even more specifically, her intense fastidiousness and aversion to anything connected with "bottoms," since her own infancy, had to be resolved.

The above instance involves another one between an adult and infant. It relates to communing, involving biological rhythms and the evidence that very dormant possibilities for such communing were being regained and reawakening in the course of an analysis. The following instances relate to myself and, I feel, have similar significance. In awareness they extend over a period of twelve years, but actually, as I will indicate, they go back more than twenty-five years, when I became interested in the relation of breathing to long-distance running, in which I trained myself.

During a holiday on St. John, in the Virgin Islands, I was sitting, looking out of the window at the sea and the sky, a scene of endless change and beauty I enjoyed often during my stay, when something happened. As I describe this instance, other personal examples and the experiences of others, there will be implied or used such expressions as, "I can't find the right words," or "It's so hard to put into words." There are many reasons for this situation obtaining. Among them are the fact that these experiences by their very nature are ineffable and inexpressible.

As I said before, even to point at, creates a dichotomy. All we can do is be silent in all languages. Another reason is that words are concepts and abstractions and static. They can only describe limited aspects of feeling, which is an on-going process. A succession of static abstractions cannot possibly describe an on-going process which is unitary. A dualistic subject/predicate language makes it all the more difficult. We are fortunate that the life of feelings will not be imprisoned in words. It ever eludes us and urges us on to better prose, poetry, music, or whatever art forms, to denote and connote it.

As I was sitting there, I became aware that I felt continuous with the floor, the building, the ground under the building, and the earth under the water, and also the water for a distance of several hundred yards out. Simultaneously, I saw a broad black line that started in the middle of my head, extended down through my body, the floor, the ground, and out into the water. Although the line was static, it had the feeling of flowing. The feeling of being continuous with all I described was quite clear. I did not feel separated from any of it. The feeling was not of being one with, but continuous with. All feeling was of continuity and none of contiguity. How long it lasted I cannot say. Maybe a few moments. There were associated feelings of newness and strangeness. While at this guest house, I had other experiences I shall describe, but I never had this one again. However, while there and away from there, it comes back to me quite often and clearly, although it was twelve years ago.

The beach there is the most beautiful I have ever seen and the water clear to a great depth. I have always been very fond of swimming and have taught myself the Australian crawl, which I do fairly well. Only in recent years have I become aware why I enjoy swimming, and this particular stroke. Suffice it to say at this point that it relates to breathing, bodily movements, contact with nature and rhythmicity of all, leading to a feeling of oneness.

The experience that occurs while swimming has occurred on St. John, at neighbor-

ing Guana Island where I have spent winter holidays, and the last three summers at Lake Lugano in southern Switzerland. I know it will not happen until I am fairly well-rested and my body has become toned up through exercise and swimming, so that the movements in swimming are approaching the spontaneous and automatic. I cannot make this happen. In fact, I have learned that trying to make it happen interfered with its happening. Also, I cannot predict when it will happen, although retrospectively, I recall that I feel a certain way. The feel is of openness and the possibility of being moved by something deep in me. I also know that when I feel this way, I feel there is a greater likelihood it will happen than under other circumstances, but there is still no certainty that it will. Because about what is truly spontaneous, there can be no certainty. The very attributes of spontaneity are unpredictability, uncontrollability, unexpectedness, and uncertainty.

The happening is simply this: I am swimming and the next thing I know I "come to" twenty-five to seventy-five feet from where I last was. After it happened a number of times, I could piece together other aspects of this happening. I might add that the general trend over the years is for these happenings to occur more often, but even now a year may pass without one occurring. Maybe a minute or two before I lose contact with my environment, or I become one with the all, or I become totally distracted, I notice my arms and legs are moving in unison and at an optimal beat, so that shortly I have the feeling as though I am disconnected from them and they are spontaneously going along on their own, without my volition. Maybe seconds after I notice this spontaneous, unitary moving of my arms and legs, I notice all my attention is concentrated on inhaling and exhaling. My head turns to the right and up to inhale and then down and to the center position to exhale. The sequence is gone through with each complete cycle of the movements of my arms, while my legs are kicking at a beat about three times as fast. I feel that instead of watching my

breathing, quite suddenly I am my breathing. I lose contact, or have this experience as I come to, when I do not know and have as yet not been able to determine. But the feel of this happening is quite clear and distinct. I and the water feel as one and I feel the water carrying me along. It is a quiet, soft, pleasant sensation. Also I have no awareness of my arms and legs moving or of my breathing. At times I have felt the sequence as follows: while being totally concentrated on my breathing, my arms and legs feel as though they suddenly click into an optimal beat and go along spontaneously. With this clicking, or immediately thereafter, comes the sensation of being carried by the water and of being one with it. It is this experience that I call communing. I would say communing was obtaining while this happening was occurring. What to call the happening while I am out of contact, I cannot say—maybe communing without awareness.

This next experience of communing I have had only since vacationing at Guana Island, four years ago. I might have had it earlier had the terrain been suitable. Again the same preconditions obtain. I must be relaxed, rested, and in fairly good physical condition. I can't make it happen or predict when it will happen, but I have the feeling, which may be an illusion, that I can sense when there is a greater likelihood that it will, and by a greater wholeheartedness and openness to its happening it seems to occur more often. It also relates to motion and breathing and the feeling of being carried, and then suddenly finding myself some distance further. Only in this case it has to do with erect locomotion up a hill. Also, what I am presenting is what I pieced together after it had happened a number of times.

The cottages are at the top of a two-hundred-foot hill which must be descended and ascended to get to and from the beach; this I did twice daily. The road to the top is about one thousand feet with an average twenty-per-cent grade. The road goes up four hundred feet and then makes a sharp, forty-five-degree left turn. It goes another four hundred feet and makes a less sharp,

ninety-degree, right turn, and then goes the remaining two hundred feet to the top.

Most of these happenings occurred in the first four hundred feet, although at times I was startled to find myself suddenly at the top. In order not to be distracted by seeing where the road turned to the left and thus see how far I had come, I would look at the road with a kind of sightless seeing. I had learned from experience at about what rhythm and beat this happening would occur and would try to feel for that pace. Sometimes I felt I was getting closer to it than at others. By contrast to the swimming, I was never completely out of contact. After a variable distance I would begin to feel my arms and legs move by themselves. Most of my attention would become concentrated on my breathing. At times I would find myself thinking, feeling, or sounding numbers or rhythmic sounds. Then would come the feeling of being carried up the hill, and shortly thereafter the mild startle-response when my eyes caught the turning of the road to the left after the first four hundred feet. I also observed with these happenings that I perspired less and was less short of breath when I got to the top.

Only after the following incident, which occurred three years ago, did I realize I had talked to no one about these happenings. As far as I could gather it wasn't that I doubted them, was averse to sharing them, or to wanting them confirmed. Maybe I had some feeling of awe about them, and did not want to tamper with them or have others do so, either. This incident was an unexpected confirmation to which, as I recall, my response was a quiet, cool, "yes, is that so?" plus a mild inner unease and an urge to move on, which I did. Subsequently, I realized that before this incident and after, others had been confirming my feelings and observations, but I had not registered or wanted to register them too deeply.

This happening occurred not on the first four-hundred-foot stretch, but half way up the second piece of road. I was brought to by a woman's laughing. I looked up and saw her twenty feet ahead of

me and a few feet in front of three men coming down the hill. Laughingly and with a surprised tone in her voice, she said, "You have been coming up that hill three times as fast as we were coming down." The three men immediately corroborated her statement in the same surprised tones. My hosts and other guests, before and since, have put it a number of times, that I go up that hill like a mountain goat. When I questioned them as to when they noticed me coming up the hill so fast, it usually coincided with one of the times I felt I was being carried up.

My speed in going up the hill, as in swimming, was an incidental and secondary consequence to me. My focus was on rhythmicity and communing. But the fact that I could cover the same distance faster and tire and perspire less is of crucial import. It clearly shows that the more connected we are with our natural organic rhythms, the more spontaneous we are. The more non-teleological we are, the more do we discover the wealth of constructive and creative resources in us. That is something I discovered twenty-five years ago, although only now can I name and describe what I then knew.

Just as Johnny Weismuller, the Olympic swimmer, was one of my idols, so was Paavo Nurmi, the great Finnish long-distance runner. Whenever I felt he would be in a newsreel, or in a documentary film on athletics, I went to see him. It wasn't his speed or the distance he could run that attracted me, but the effortless, unhurried gliding along, with his whole being seemingly moving in unison, that thrilled me and filled me with awe. Another thing that intrigued me about him was that he never competed with other runners, but only with his wrist watch, setting so much time for each distance and for the total. Also he was described as quite fresh at the end of long distances that left others exhausted and drained.

I had never done any running as a youngster or in college. I felt I was slow and I had no interest in the sport. My medical-school dormitory, however, was close to the Fenway, a long winding park-

way, running from the center of Boston well into the suburbs. Shortly after I arrived I began to run and by the end of my medical-school career I could run five to six miles fairly comfortably. But this only happened gradually, as I discovered many things about running, rhythm and, breathing and what is known as the second and even third wind. Although Nurmi was my idol, it took time before I let go of the need to run fast and far, namely, the competitive aspects. About this and about how our need to win defeats us, I shall say more later.

At first I became winded, breathless, and easily exhausted. In time I could run longer, to the point of getting a 'stitch in my side,' a left lower abdominal pain which would double me up and force me to stop. As I could stay with this pain more, I felt squeezing pains in my chest and the taste of blood in my mouth. Also I would begin to feel unbearably hot. As I could stay with and not fight these feelings, they would reach intolerably painful proportions and I would have to stop. Staying with it longer, something finally began to happen. At the peak, with extreme pains in my side and my chest, and the feeling I couldn't hold out any longer, all of a sudden there would be a letting-go feeling. With it I would feel relaxed and rested and a surge of new energy from deep inside me would carry me a further distance, almost as far as I had come. I recall the feeling of surprise and pleasure when it happened and now, retrospectively, feel there was some aspect of awe and unease, as well.

In the earlier phases of my experience in running, I would on occasion go from renewed wind to another peak, to catching my third wind. With more experience, less competing and more quickly and easily finding the optimal rhythm and pace, I could run much further before the onset of rising tension and pain that came before the second wind. I can still recall the pleasure in the rhythmical movements of my arms and legs as I felt myself being carried along. As happened in the swimming, there was also pleasure in discover-

ing the depth and extent of the energies and resources in me, once I learned the ways to tap them. And I feel these deep wells of creative energy are in all of us. From time immemorial, people have been seeking and finding new and different ways to reach them. I have already mentioned some of them, including psychoanalysis, in Part I of this paper. I feel that the more we are aware of the nature of, the forms of, and the ways to human communing, the more we will be able to help ourselves and others to find their way toward those immeasurable creative depths available to be tapped.

#### GAINING, AWAKENING AND RECOGNIZING COMMUNING

The following example relates more to gaining, awakening, and recognizing creative depths and to communing with natural organic rhythms and nature than to regaining and reawakening something that had been there and was lost, or had never been developed because of life circumstances. It was necessary for Roger Bannister<sup>4</sup> to have many of the experiences I have described to be able finally to break the psychological barrier of the four-minute mile. Once he had done it he was able to repeat it shortly thereafter, and others who had failed or were just beginning to try, discovered that they also had it in them to break four minutes. There is an interesting psychological sidelight on the four-minute mile. One well-known runner's barrier is his inability to be first. He has run the mile under four minutes a number of times, but only if someone is running a little faster ahead of him.

Bannister describes his awakening, his discovery, poetically. "I remember a moment when I stood barefoot on firm, dry sand by the sea. The air had a special quality as if it had a life of its own. The sound of the breakers on the shore shut out all others. I looked down at the regular ripples of the sand and could not absorb such beauty. I was taken aback—each of the myriad particles of sand was perfect in its way. I looked more closely, hoping that my eyes might detect some flaw. But

for once there was nothing to detract from all this beauty.

"In this supreme moment I leapt in sheer joy. I was startled and frightened by the tremendous excitement that so few steps could create. I glanced around uneasily to see if anyone was watching. A few more steps—self-consciously now and firmly gripping the original excitement. The earth seemed almost to move with me. I was running now, and a fresh rhythm entered my body. No longer conscious of my movement, I discovered a new unity with nature. I had found a new source of power and beauty, a source I never dreamt existed."

I want to repeat certain words and expressions Bannister used which are identical with or close to those I have already emphasized. Although much may precede, as it does in an analysis, what stands out is a remembered "moment," and it was from a number of such moments that our horizons widen to include what seemingly was beyond them. Bannister speaks of "sheer joy" and of being "startled," "frightened," and "glancing around uneasily." This is his way, I feel, of describing his feelings of awe and of unease close to dread at the discovery of this "new unity with nature." Note also his expressions "the earth seemed almost to move with me," "a fresh rhythm entered my body" and the implication of finding something that already had been created in him, as if by some outside agency.

Following this moment were others, and then he "unexpectedly" won a mile race against Cambridge. I have emphasized the unpredictable and unexpected aspects of these happenings; this one "gave me a glimpse of the future because I had discovered my gift for running—an unconscious conspiracy of mind and body. . . . I knew from that day I could develop that newly found ability." Note that he speaks of a gift, something given into his keeping, to be honored, respected, and developed. The poetry of "an unconscious conspiracy of mind and body" is evident. And again he speaks of something "newly found."

Following these happenings were many failures and disappointments while he was learning the ways and possibilities of developing the gift in his keeping. And when he finally breaks that impregnable barrier—the four-minute mile—his response is not only joy, it is joy and anguish. It is fitting that he should close his book with the statement that “the human spirit is indomitable.” Not just the human spirit of Roger Bannister, but the human spirit in all of us.

#### BREATHING AND INSIGHT

The relation of organic rhythmicity and communing is evident in a number of the examples already given. Elsewhere I have dwelt in more detail on the subject of rhythmicity in all aspects of human being and being human.<sup>5</sup> The crucial connection of rhythmicity and breathing has been known for centuries and is highly developed in various forms of Yoga. It has long been known as well that breathing exercises are an essential aspect of the training for making contact with those aspects of our being that obtain in communing. Ultimately, through becoming them, we—each one of us—are Buddha. The connection of breathing, insight, and the “aha” experience will be discussed more in detail after I give a clinical example which elucidates the connection of the change-of-breathing pattern with insight. I want to add at this point that disturbances in breathing patterns are very common and that changes toward the natural are quite frequent in the course of analysis. These disturbances in breathing patterns are as common in men as in women. I am speaking of instances where there is no lung pathology. A great number of people discover in the course of their analysis that they literally have been holding their breath all their life. Behind such breath-holding one often discovers fear, anxiety, panic, or leashed anger, hate, and fury.

In an existential sense, these people have been holding back life possibilities. Their being held back implies they are there to be held back. However, they experience the holding back as though an

outside agency were doing it to them: “Someone is sitting on my chest,” “I feel like there is a vise around my chest.” This breath-holding may obtain in people who have been athletes and trained in breathing, and yet who never have been aware, or had it brought to their attention, that they were breath holders. When they first begin to breathe naturally, as their analyses process, they become frightened; they become aware of what is happening and start holding their breath again. The special pattern of breath-holders is plainly visible on the chart when they take a basal metabolism test.

When one man began his analysis he was aware of the crucial role his father, a colonel, had played in creating his neurotic difficulties, but only gradually was he able to become aware of the extent and depth of his father's influence. His father, as he pictured him, was an all-knowing, benevolent tyrant, constantly questioning, correcting, and criticizing him. The son felt surrounded and had resorted to living in imagination as almost his only escape. His mother was there, but almost no help or support to him. As the analysis proceeded, he became aware of a pressure on his chest, accompanied at times by mild coughing fits. In time he associated the pressure with a trapped, paralyzed feeling. He began to connect the feeling with his father and referred to it as the feeling of his father sitting on his chest. His father regarded enjoyment and playing as wasteful and was always impressing on his son the need to learn, and to do useful, “right” things.

The patient enjoyed playing tennis and was fairly good at it. Discussing it he mentioned a “Joe DiMaggio” feeling. When he had this feeling he said he “played the game,” played well, and enjoyed it. When he didn't have it, he felt tied up in knots and, as he put it, was “trying to beat the game.” In short, he had come on the awareness that when trying and competing and being focused on beating, he was tight, got tighter, and played poorly. When enjoying and playing were one, he played well, but as a secondary consequence.

Much of what I shall describe about DiMaggio my patient stated or implied. This is what I have gleaned from the reports of many people on many different occasions. Of DiMaggio's playing as an outfielder, it is said that he ran like a gazelle, easily, gracefully, effortlessly, and unhurriedly. Yet he moved with considerable speed. The other aspect of his playing was baffling. It almost looked like magic and was what made him a truly great player. As the ball left the hitter's bat, he would start running. And time and again he would be under the ball as it fell toward the ground. It was as if he and the pitcher and the batter and the ball were all one, communing in one flowing process, ending with the ball falling into his glove. In almost these same words, my patient described his feelings playing tennis. As he heard the sound of the ball on the racquet, he would start moving with a feeling for where the ball would land and how. When this mood was upon him, he played excellently and received many confirmations of it. Friends also compared his playing that day with other times when he was "beating the game." I also noted, as he talked about these DiMaggio days, an undercurrent of unease. He seemed to want to mention it quickly and get it over with. Also he seemed to convey a feeling of discomfort as he mentioned the positive comments of his friends about his playing.

During the course of a Monday session, he felt a letting go, a clarification and upsurge of hope, having come into the session a bit frightened that what had brought him into analysis a year before was recurring. On Wednesday he related that the evening before he had had a very enjoyable evening out with his wife, and had stayed up rather late. He noted a slight scratchiness in his throat, but felt hopeful it would disappear as it had following a session on several previous occasions. When he came in Friday his cold was worse, and he told me he had felt a little slowed up Thursday and more so on Friday, with several outbursts of irritability. During the whole session he felt stuck and paralyzed. He didn't have much to say and by the

end of the session was getting a bit panicky. He mentioned in the beginning of the session—sort of trying to laugh it off—that he was "being chastized by the colonel for having enjoyed himself too much." I felt he was having quite a repercussion, and mentioned to him that, though he felt the session was wasted, in time he would become clearer about how much he had got out of it. Monday was a holiday. I was to see him Tuesday. He cancelled that appointment because his cold was worse and he also did not go to work.

When I saw him Wednesday he said his cold was about the same Saturday and Sunday, and that he had played tennis both days, hoping to sweat the cold out. He reported that on Sunday he had played particularly well and had had the Joe DiMaggio feeling quite a bit. Many of his friends remarked how exceptionally well he played. My patient said, "I was playing. I wasn't trying to beat the game. I was enjoying myself very much." That night, about 3 a.m., he had gotten up to urinate. He recalled quite clearly just as his head met the pillow, almost out loud the words came, "Get off my chest," and he quite clearly knew what he meant. He was telling his father, the colonel, quite clearly, and with more confidence than he had ever felt in his life to stop interfering with his enjoying life.

The next day, Monday, his cold was worse and he stayed in most of the day. As he lay down to go to bed that night he noted a change in the pattern of his breathing. Where before he had been an abdominal breather and his chest breathing was shallow, he now noted that his chest was expanding and contracting over a wide range. There was less abdominal breathing and, as he put it, he "felt looser in general." When he cancelled his session Tuesday and didn't go to work, his cold was about the same. Wednesday he began to improve. He related all the above in the session that day and said, "I saw more what you meant about what I might get from that Friday session. I see I didn't want to admit what a strong hold my father still has over me." In the Friday

session, he began to experience and become aware of the many aspects of self-hate he couldn't let himself experience the week before. The effect was a further loosening and hopefulness.

This example clearly reveals the connections of the analytic process, working through, insight and a change in breathing patterns in the direction of natural rhythmicity. It also clearly reveals the pattern of hanging on and letting go at the same time, with resulting paralysis, exhaustion, panic, and even despair, ultimately ending with letting go and then, suddenly, clarification. "Get off my chest." This example was brought to my attention because of this patient's sensitivity in such matters, as evidenced in his comments about his Joe DiMaggio feelings. In fact, discussions of those feelings came out in our exploring a recollection from age fifteen when he was playing quarterback in an intramural football game. What he did was regarded as sheer wizardry by the coach and everyone else. It never had happened before or since. As he said, "I don't know what happened to me. I wasn't thinking about what plays to call. The signals just came out of me and everything was clicking. Something was happening and it never happened again. Not long after I was dropped to second string."

#### INSIGHT—LAUGHING AND CRYING

In Part I, I mentioned the similarities in the patterns leading to *satori*, the creative process, creative insight, and clinical insight. Suzuki, Ghiselin, Hutchinson, and Martin all emphasize the abruptness, unexpectedness, and unpredictability of the something new coming through and of the person becoming something new and more at the same time. All describe a period before this happening as one involving the whole person in struggle, conflict, and friction. Hutchinson and Martin describe the bodily phenomena and facial expressions. Martin is quite explicit in his description of the "aha" experience that simultaneous laughing and crying occur. The close association of laughing and crying and the ease with which one passes from one to

the other have been known for centuries and appears in endless stock sayings. But how insight occurs with laughing and crying, and not with fear and anger, is a question that has intrigued me. The facts I describe are observable by anyone, the hypothesis is mine.

In laughing, the pattern is to make a large inspiration following by smaller and larger expirations until another inspiration is felt to be needed. In crying, the pattern is more usually a number of short inspirations, followed by a single large expiration. However, at times it may be similar to that in laughing, and on occasions shift back and forth from one pattern to the other. Note that with both there is almost constant phasic activity, constant expanding and contracting, and constant struggle in the form of grabbing hold and letting go. Also, energy in the form of atmospheric oxygen is being taken in and used, and carbon dioxide is being created and expelled, in fairly rapid succession.

In fear, anxiety, and panic, there is a sudden, quick inspiration usually of small or moderate size. The whole chest and even the whole body is kept rigid, with the heart racing. The whole picture is one of being rigid and static and, when not overwhelmed, poised and ready for flight. In anger, hate, and fury, there is a slow to rapid inspiration, following which the chest and even the whole body is held rigid and the feelings held in leash. Heart action is usually slow, forceful, and pounding. The picture again is static and rigid.

In laughing and crying the person is these feelings, the conflict, the struggle, the friction. To say he is self-directed or participating in these feelings is not quite accurate because the language sets up a dualism which is not there. In fear and anger, the person has those feelings and is other-directed, with the objective of flight or fight. The struggle, conflict, and friction will take place outside or with reference to the outside. It will involve a single peak action with catabolism predominating. By contrast, laughing and crying as part of clinical insight is a continuing, on-going process. In short, everything about the

feelings and bodily attitudes associated with fear and anger are antithetical to insight, i.e., to expanding one's inner horizons, while those of laughing and crying most definitely are conducive to such widening and deepening.

#### COMMUNING AND COMMUNICATING

Throughout this paper I have pointed up in as many ways as possible the difficulties, actually the impossibility, of communicating communing. What I am attempting to do by a host of examples is to present as many aspects of the process, as many ways to experiencing it, as I feel will help prompt responses of awareness, familiarity, or congeniality. I hope that from these examples and responses people will rediscover similar experiences in their past, and be more alert to their occurrence in future. Time and again, I have emphasized that even these examples are not the experiences but about the experiences. They are expressed in a dualistic language after the experience has passed. When communing is obtaining there is only communing. There is no one who is communing and, hence, no one who can communicate the communing experience.

Maybe I can clarify a bit more what communing is by saying what it is not. Communing is not communicating. So often when I have talked about communing, people have heard me say communicating or communication or they have said, "Yes, I know what you mean, communication," which, of course, I did not. Although some will say, yes, they know I am talking about communing, they will promptly ask me, "At what level does communing go on?" Communing is happening at no level and all levels. Some will experience this as a typical Oriental evasion of the issue or as doubletalk. It is not, but only seems so. The questioner doesn't know it but he is asking his question from a dualistic, logical frame of reference and I am answering from a unitary experiential frame of reference. The whole notion of levels, superior/inferior, and of a me talking to a you are part and parcel of dualistic thinking. To help clarify some of

these difficulties, I shall describe all that is not communing, that represents levels of abstraction from it. Put the other way, as we remove these levels or descend the scale, we come closer and closer to communing. Elsewhere I have defined what I called the symbolic spiral and the symbolizing process.<sup>5</sup> I said what we start with is pure fact, following Northrop's definition. When communing is obtaining it is constituted of pure fact. The metaphorical symbolic spiral is a sequence or continuous series of connected levels of abstractions starting from pure fact.

"Strictly speaking . . . we can say nothing about pure fact . . . words point it out; by themselves they do not convey it. This means that pure fact must be immediately experienced to be known. At least its elementary constituents cannot be conveyed by symbols to anyone who has not experienced them. But to say this is to affirm that pure fact is ineffable in character. For the ineffable is that which cannot be said, but can only be shown, and even then only to one who immediately experiences it. Furthermore, since ineffability is the defining property of the mystical, it follows that the purely factual, purely empirical, positivistic component in human knowledge is the mystical factor in knowledge. The pure empiricists are the mystics of the world, as the Orientals, who have tended to restrict knowledge to the immediately experienced, clearly illustrate."<sup>6</sup>

Symbols are forms. The moment we are aware of having a feeling, no matter how vague and unnameable, the fact that we are aware means it has taken shape. And the shape, the form of what we are naming a feeling, is already an aspect, an abstraction from pure fact. This has been most difficult for many to feel into, or more accurately, feel. When I have said, "One cannot have a feeling in consciousness or awareness," patients have become anxious and insisted irately, "Nobody is going to tell me I don't know what I feel." Of course they know, and that is the issue. Knowing is labeling, is a concept, which is *about* the feeling and not the feeling itself.

So we could define communing as what is obtaining before forms, patterns, and symbols begin to appear. While communing obtains, there is not a someone from whom something flows out to someone else and/or from whom something flows back. With the latter there is already a dualism, even though the cues, clues, and signals are flowing on a quite unconscious non-verbal level. Communing is obtaining before and beside the question of verbal and non-verbal. The levels of communicating having to do with the non-verbal, in which there is now so much interest, are closer to communing than the verbal, but still have to do with dualisms and abstractions. I am not denying that communicating exists. On the contrary—and sad to say—I feel the verbal is the level on which most of our existing, not living, goes on, and all too little of it is made up of moments of communing.

What I have tried to point out is that the less we are involved with, and distracted by, higher levels of abstraction, the more we are able to be silent, quiet, and still and to listen with more and more openness, making us more and more available for communing. To indicate further what communing is not: it is not affective contact, empathy, Buber's I-thou in the context of the eternal thou, nor is it *begegnung*. These point in the direction of communing which I feel goes beyond them and is on another plane.

I want to mention again some of the examples in which I felt more and less of communing obtained and, hence, that what communicating occurred was all the more meaningful and effective. There is the communing of man with nature in general, with plants, animals and humans, infants and adults. We know the strength of the bonds created between children when they communicate their deepest secrets in bed after the lights are out. The lessened opportunities for such moments through the spacing of twin beds are important modern factors causing difficulties in marriage. Communing may occur more easily and communicating go on at deeper levels when one is less than fully awake.

I have mentioned mothers caring for their infants without recollection of having done so in the morning, and of infants coming to their parents' bed and being returned to their own, also without recalling it. Husbands and wives have reported to me in analysis that one or the other was restless, and mumbled or talked in his sleep, or had a nightmare. The more relaxed one, the husband (or wife) who has been awakened, will take his wife in his arms, cuddle her, and after he feels she has quieted down and relaxed, slowly disengage himself. He will report that shortly she will roll over, fall into a deeper sleep, and have no recollection in the morning of what transpired.

A man who had such an experience with his wife reported that about six weeks later she told him that the night before she had had a "very real dream." In it she felt she had had a nightmare, during which she had reached over, put her arms around him and that he had held her. She had the feeling of being half awake and half asleep, but couldn't be certain whether it was all dream or whether it had actually occurred. Her husband told her that it had happened on the night before but also on previous occasions. When he told her this she recalled other similar dreams. However, in those, as well as in that of the night before, there was other material she recalled that went much beyond what her husband had observed. So how much was dream and how much awareness on the part of the wife while half awake would be difficult to evaluate.

I said above that communing is more possible the closer we are able to be to nature and to natural organic rhythms in ourselves and others. This becomes more possible the more we are able to be silent, quiet, and still or, to put it another way, the less we are blocked off and alienated from what is natural in us by acquired sick patterns, which are distortions of what is natural, and by distractions from it. What I want to point out is that even when there is a deep and extensive degree of sickness, the degree of communing still possible is quite remarkable. The more

we are aware of this, have faith in it and rely on it, the more hopeful and effective we will be in our therapy. There are many indications of how much communing did and does obtain. One is the constructive results in therapy immediately or ultimately evident. Another is the evidence of the extent and depth of communicating that can go on even in extremely disturbed states.

Here again I wish to make some further distinctions. Thus far I have tried to indicate what communing is and what it is not. I have also tried to point out that when communing obtains, a unitary experiencing process is happening and that when there is communicating, feeling and thinking is going on in a dualistic frame of reference. There is one who communicates and a recipient. But there are some further distinctions. There is what is communicated consciously and unconsciously and what is consciously and unconsciously received. There is what is intended to be communicated and what is intended to be listened to. And this only begins to point out the intricacies of the process in communicating. It is remarkable that we understand each other as well as we do and that we can help people as much as we do in spite of infinite possibilities for mutual misunderstanding.

#### COMMUNING CONFIRMED YEARS LATER

Eight years after a patient's first session, what she felt and thought came up in response to exploring her compulsiveness, perfectionism, and her need to cover up and to criticize herself for unpremeditated pleasure and spontaneous feelings. She said, "I am beginning to see with clarity how much pushing away I have done even in analysis. They burst through. Those are the things that come through, that made me fear solidity from the first time I came here. Well, I covered and now I have uncovered. That's why I continue to come here, even when I left here dejected and sick. Actually, I knew there wasn't anybody who cared as much as you did, no matter how many things I tried to obscure. I was there, much as I dreaded pain, and was angry with you when I left. I could barely wait for the next time to come. Cer-

tain things stand out in my memory about the first time I came, such as walking into this house. I could feel a complete lack of pretense which I had never felt any other place since I had been to see Dr. A. (whom she had seen four years before about her son's therapy) and Dr. B. (with whom she had a consultation two years before about therapy for herself). I was afraid. I was always afraid. There was a feeling about going into the living room. There were the plants and the pictures. The living room made me feel good. I had been so lost in space in those big offices (of Dr. A. and Dr. B.). Big places represented to me help at a great distance. Now I'm getting all warm. You didn't have a secretary. There was nobody in between. It would be between him and me I thought."

I asked, "What else about covering and uncovering? Sitting on and getting up from?" "Covering of my spontaneous, my natural feelings. Sitting on what I felt like that day. Wasn't good or ladylike, or perfect thing to do. It was a keg of dynamite I was sitting on which kept shooting off against the world and against myself. This is where I learned to stand on my own feet, to throw a pillow at you and to do all the things I have dared to do." She spent the rest of the session reviewing her course in therapy.

In subsequent sessions she talked in more detail about her first session and how she felt in the years before coming to therapy, while she was still fighting it. I could corroborate the accuracy of her recollection from my notes. Also, what she recalled was extensive and detailed. And what was her mental state on the occasion of that first visit? I shall use the words she used about herself then and which had been applicable for the previous ten or fifteen years of her life. She felt remote, foggy, and as though she were living in an unreal world. Her pull to death and self-extinction were powerful. She often wished she would not wake up. There were powerful death wishes and unconscious self-destructive impulses. She was constantly hiding and avoiding human contact. Much time in her analysis was

spent on her need not to look and not to see, not to hear and not to listen, avoiding, evading, hiding, obliterating herself and of the world. These are enough to indicate the blocks to communing and communicating that obtained. And her own words indicated how much in fact did obtain, despite those extensive and deep-seated blocks to her feelings.

Another woman went through a suicidal period after several years of analysis. The acute phase lasted about two weeks. During it there was excessive use of sedatives, little food and liquid intake, and excessive infliction of minor and major physical hurts to her body. Her sensorium was clouded but appeared to be much more so. The pull toward oblivion and death was powerful. Five years after this episode she went into what had happened. Obviously, during that period much of her sensorial disturbance could have been due to her severe anemia, to malnutrition, avitaminosis, dehydration, excessive drug intake, and mild fever. Yet as she explored that period the recollection of detail was quite startling. She recalled verbatim many things I said. Several statements I made at the time had a deep impact on her. They shocked her, brought her up short, and caused her to begin to pull herself together. In fact, following this suicidal phase there began a turning toward life which became wider and deeper as the analysis proceeded. Here again, without the depth of communing that had obtained, I could not have said what I said nor would it have had the effect that it did. What was particularly impressive was that even with all these obviously physical bases for a disturbed sensorium, there was virtually no interference with reception and retention. There are indeed levels of human continuity and connectedness which obviously contradict what would seem to be an understandable and logical consequence.

And what did I say to her that was so shocking and had such deep impact? I said, "Do you realize you are trying to commit suicide?" This was evident to an onlooker and not too far out of her awareness. But she had not used the word, sui-

cide, to herself. My explicit and concrete use of the term, putting what she was doing in words and saying it to her in an affirmative manner, got through to her and made it real. The second thing I said was, "You do not believe that I am going to let you destroy what we both have built with great effort and pain? I do not allow others to destroy what I have helped to create." What had a particular impact on her in these statements was the "we" aspect and the assertion that someone, myself, would put such value on the product of his labor that he would put up a real fight for it.

This experience may be illustrative of what the existentialists refer to as *kairos*, a term revived in theology by Tillich<sup>17</sup> and introduced into psychotherapy by Kielholz.<sup>7</sup> *Kairos* in Hippocratic medicine meant "the typical moment when an acute disease was expected to change its course for better or worse." Kielholz feels such instances are much more common than believed, but are not recognized because the usual ideas in therapy are that there must be a slow evolution and resolution in the therapeutic process. He feels that with skillful handling of such crucial moments "rapid cures of cases which were considered severe, if not desperate" could be obtained with "neurotic, psychopathic, or even psychotic individuals." I have observed other instances similar to the one related above and feel I have been quite effective with such more active intervention. However, in my experience, such occasions have not been rare but uncommon; and I would not speak of cure, a concept of which I am quite dubious. Crucial turning points in therapy, yes. Very significant changes through well-timed, thoughtful, and affirmative efforts, yes. But cures, no. In the above instance, and in several others I could cite, the analysis went on for a number of years after, and in the eyes of both of my patient and myself the continuation of therapy was essential and productive.

The next woman I want to mention was even more remote and distracted from her natural rhythms. Such extreme alienation would be expected to block, interfere with, and distort communing and commu-

nicating. I am including her history, so that the incisive lessons it teaches may be read and, hopefully, better understood.

In 1931, on the female reception service of Kings Park State Hospital, I carried on a research project using CO<sub>2</sub> and O<sub>2</sub> inhalations for the therapy of catatonia.<sup>8</sup> What these patients received was intensive and extensive contact with me and the staff in the form of interest, concern, and time, plus my limited competence as a therapist. My contact with one of them—Dora—extended over a year, the research aspects lasting about two months. At that time she was twenty-five. She had been in and out of hospitals since she was nineteen. In most of them she had been diagnosed as suffering from dementia praecox, Hebephrenic type.

I saw her next in 1944, thirteen years later. Before she arrived I reread the detailed notes I had of my work with her in 1931. She came with her mother, who informed me that for most of the intervening years Dora had been hospitalized and that she had been harassing her to arrange a visit with me. Exhausted and in desperation, the poor woman finally gave in to Dora's insistence.

Dora, now thirty-eight, had developed hypertension in the interim. What was startling was the detail and the clarity of her recall of the period, 1931-1932. She recalled the members of the staff and the other patients, and many of their personal characteristics. She also recalled a great deal about the therapy she had received and much of what I had said and done. Her recollections far exceeded mine. I knew that without my notes I might have doubted the validity and extent of her recall. Undoubtedly, the difference was that the experience had been and still was far more vital and alive for her than for me.

The frequently reported phenomenal retention and recall of patients, psychotic and mute up to ten and fifteen years, has often been reported. It also has been observed that illness can go on that long without the occurrence of predicted deterioration. This had been the case with

Dora, but something more also was involved, and it is this to which I am drawing attention. Some people are interested in psychotic patients and can and want to work with them and some are not. This is well-known and does not reflect credit nor discredit. It is well for therapists to be aware of this, and work with patients with whom they feel most effective. I feel I have had the ability to work with such patients, and did so long before I knew what I was, in fact, doing. It was this plus what was communicated as interest, caring, time, effort and what I did that I believe Dora felt. But without communing obtaining, I do not believe that what happened in and with Dora would have been as living and alive when I saw her thirteen years later.

#### COMMUNING CONFIRMED SHORTLY THEREAFTER

The above examples relate to recollections of situations long past and in a context of chronicity. I want now to give some briefer, more dramatic examples of intense disturbances of consciousness and of reinstatement to a more integrated, though still quite sick, state of equilibrium in periods ranging from minutes to several months. I feel the sequence happened in each one because communing obtained. Levels of communicating closer to pure fact were possible, which accounts for the effectiveness of what transpired.

In the fifth year of a quite stormy analysis, a man who had been sitting on the couch for the first ten minutes of the session suddenly got up, walked over to the chair in which I was sitting, stood over me, looked at me with considerable hostility, and let loose a diatribe of venomous accusations and criticisms. He was obviously extremely frightened, agitated, hostile, mistrustful, suspicious, and paranoid. His threatening words and gestures went on for some minutes, while I looked at him quietly, steadily, interestedly, concernedly, wonderingly. I was not frightened or trying to appear calm. I was calmly trying to be as open as possible to what he was saying and to my feelings, so I could connect with his depths and feel what it was that

was disturbing him so. I did not say a word and, obviously, did not take notes. After about twenty-five minutes, he stopped for a moment, looked at me intently and quizzically, and with a new tone in his voice of wonder and puzzlement, he asked, "Why are you looking at me that way?" I said, "Because I'm wondering who you are talking about?" He said, more quietly and with doubt in his voice, "I'm talking about you." I said, "I don't recognize myself in what you said. It doesn't sound like me at all." With this he looked and became quieter and also more frightened and puzzled. After a few moments he turned and went back to sit on the couch where he remained, saying very little until the session ended. I am quite convinced that if communing had not obtained this incident would not have transpired, nor would his subsequent analytic work with me have taken the course it did.

The following occurred during a woman's analysis, after quite some psychiatric and analytic work with a number of other therapists. In the weeks prior to this session, she had been becoming aware of the amount of fury and hatred in herself, whereas all her life she had felt herself to be good, kind, and considerate. In the preceding months, an intense struggle had gone on about asking for an extra appointment and about breaking down and crying during a session. Her last session had been on a Friday. On a Sunday afternoon, a female friend called, initiating the call after a lot of back and forth with my patient whom I could hear sobbing violently. I could also hear her shouting that she did not want to come to see me and that I could drop dead. After I talked to her through her friend, she finally agreed to come to my office.

The moment she came through the door, she fell on the floor of my foyer sobbing violently, with her back to me and her head on a chair that was set against the wall. I sat on a chair next to it saying very little and that only after some minutes and in a very quiet voice. Her sobbings were interspersed with violent pounding of the chair and violent expressions of

hatred. She then mentioned a realization that had come to her in the past few days and that had appalled her: that all her life she had wanted to punch pregnant women in the stomach. After about forty minutes, because I felt she might be disturbed by hearing people in the hallway using the elevator, I suggested she might come into my office, which she did, keeping her back to me and not looking at me.

I sat on one end of the couch and she got on the couch, resting on her knees and on her side with her head on the pillow away from me. The sobbing and the expressions of violent hatred and fury continued for about ten more minutes, at the end of which time she sat up and turned her face toward me and with a surprised look and smiling expression said, "Oh, it's you, Doctor Kelman. This is the first time I saw you." She remained for about fifteen minutes more and then left. During that period she said little and it was obvious she was quieter and more relaxed.

The next day, in her session, she told me that she had felt me throughout Sunday's visit. She used the words, "I felt you all the time, but it was only when I turned around and looked at you, I suddenly realized I hadn't looked at you up to that point." She had had a terror and a hatred of the couch and had not been on it once since she started her work with me a year-and-a-half earlier. In her Monday session, she expressed appreciation of the fact that she had been able to "break down and sob," and that I had seen her on a weekend. The third thing that happened was that she finally got on the couch, although she didn't mention this. Incidentally, she has remained sitting there in a number of positions since.

I again want to emphasize that, had communing not obtained, I doubt that she would have come in the first place, stayed in the second, and made the many emotional changes she did in the course of the session. When she said, "I felt you," she meant it not only figuratively but literally and with her back to me. The feeling of feeling me was so clear and definite, she was not aware that she was not seeing me.

Her position with reference to me certainly excludes many sensory avenues for cues and clues of a non-verbal nature for feeling me. In this instance maybe we are in the realm of parapsychology and maybe beyond.

Although the following incident happened about eighteen years ago, I still recall it quite vividly. I was Chief of Neurology and Psychiatry in a large general hospital. Mine was an open ward with a single isolation room that had a solid, heavy door and barred windows and was used temporarily for very disturbed patients. Opposite it was a six-bed ward. One day I was called by the nurse to come and see a male patient, a merchant seaman, about age forty-five. He was huddled up on his side under the bed in the isolation room. He normally occupied a bed in the six-bed ward opposite. When I came to the door of the isolation room, several patients, the internes and my assistant were standing around, rather disturbed, as was the nurse.

I stood at the door for a few moments saying nothing and looking at the patient. As I proceed you will see many similarities in my behavior with that of the grandmother and her four-month-old grandson. I interpret my behavior then in terms of what I know now, which I was quite unaware of at that time. To use an expression which needs much definition, I went on intuition. I stood there until I felt my patient had become a little accustomed to me and less frightened. I then took a few steps into the room, remained still for a while and then moved again. I then lowered myself to my knees and then to a sitting position on the floor, always remaining still for a few moments or minutes until I felt my patient had accepted me in this new position. Up to this point I had said nothing, always looking interestedly, concernedly, and intently at him. At this point I called his name quietly several times. I was now sitting opposite the middle of the bed and two feet from it. Simultaneously edging closer a bit, pausing and calling his name, I moved to within a foot of it and then I lay on my side, full

length, facing him. After this, I bit by bit edged under the bed until I was holding my patient's position, facing him, about one foot away.

After a few moments, I noted that he turned his head to the barred window and with it his eyes showed increased fright and terror. Having gone through this mutual moving together, I began to quietly say, "Yes," and nod in agreement when he made some inaudible sounds. Assuming he was delusional and hallucinating at this point, I would nod in agreement, say "Yes," and then try to indicate I was aware of someone menacing there, outside of the window. Now and then I would intersperse his name and then began to say, "I'm Dr. Kelman, Jensen." After about ten minutes of this he began to relax and with this I began to edge out from under the bed, with pauses and repetitions of his name. After I was again sitting clear of the bed, I began to ask him if he wanted to come out from under the bed. After a while he did so. Then I asked him if he wanted to go back to his bed. In a few minutes, when I felt he was sufficiently relaxed and accepting of me, I touched his elbow. Up to this point I hadn't touched him, feeling that the contact would disturb more than assure him. Again after a few moments I got to my feet, helped him up and led him back to his bed. I helped him get in, covered him and suggested to the nurse that she watch him for a while and that his roommates also stay with him.

About fifteen minutes later, a roommate came rushing for me to come to the room. When I got there Jensen was quite agitated, frightened, and kept asking, "Where am I? What happened?" I took his hand and repeated to him, "You're all right Jensen. You're in the hospital. I'm Dr. Kelman." I didn't say all this at once, but in parts, and adding as I went along. He quieted down in about ten minutes and dozed off. I spoke to him about one hour later. He was quiet and more relaxed. By indirect questioning it became quite clear he had no recollection of what had happened to him. He made no further allusions to this episode during his hospital

stay and left about two weeks later, considered fit for duty.

Looking back I would say I was intuitively aware that to help this man I had to be continuous and contiguous with him. By continuous I mean feeling what he was feeling both physically, next to him on the floor, and in my being, so that he could feel I felt what he felt. This to me is communing. By contiguous, I mean not only being physically close and separate as a physical identity, but separate as an identity having a feeling of myself as uniquely me. Later I shall discuss more at length the relation of feeling simultaneously separate-ness and togetherness, and their connection with communing. However, without having laid the basis for communing, I feel my communicating in the ways I did would not have been as effective as they were. The whole episode lasted several hours. It reveals a shift in the patient's usual state of consciousness to a transient state of panic, accompanied by delusion and hallucinations, and back again. I did intuitively then what I would do now with awareness and also with greater effectiveness in helping him go through what he had gone through.

Devereaux described his experience<sup>9</sup> with "Jimmy Picard," a Plains Indian and war veteran who was "either psychotic or X," as "trans-cultural" psychotherapy. To it he brought psychoanalytic and anthropological training, as well as his extensive interest in parapsychology. What has relevance for me is the concern for individuals, people, and the transcendental in people implied in Devereaux's interests and in the factual result he obtained with his patient. To me it implies that kind of openness and wholeheartedness to otherness and difference that leads to communing obtaining, which means not only deep awareness of similarities but of identities. Without communing having obtained, I do not see how his result could have been possible.

Only brief therapy was available. The objective set was rehabilitation to a reservation. Conflict between his ancestral and present-day, vestigial Wolf culture and American culture was recognized. The pa-

tient was accorded his unquestioned right to remain a Wolf Indian and a unique person with a traditional way of life. Among Plains Indians the most significant relationship is with the Guardian Spirit and not the father. Dreams are treated as real incidents of actual behavior; the Indian feels responsible for his dreams. They could be used for reality pre-testing and the burden of the "transference" could be shifted to the Guardian Spirit. Devereaux was guided by Freudian constructs in his thinking and therapy. Using his total knowledge and experience and regulating the amount of insight his patient was capable of integrating, it was possible to discharge the patient from the hospital and return him to a reservation within a few weeks. Follow-up revealed no relapse. It was recognized that change of a fundamental nature had not occurred, but that "ego defenses" were healthier.

The essential point in this therapeutic experience is that influencing people effectively is possible even where the differences and distortions include those of a psychogenic, as well as of a cultural nature. Furthermore, this can be possible only where communing obtains to the degree I feel it did in this case. A further evidence of it—besides the breadth of Devereaux's interest—was in not only allowing but encouraging "Jimmy Picard" to be a Plains Indian. And he helped him to become that by reacquainting him with the deepest values of Wolf culture. By the end of therapy, as "Jimmy" was experiencing it, it was no longer the white man who had taught him, but a Great One of his own kind. Now he was a whole man, who happened to be a Plains Indian, living a fuller life.

The story of "Jimmy Picard" brings us to the whole subject of communication and applied communication. I have attempted to distinguish communing from communicating in general. I have been discussing only one specialized aspect of communicating, namely, in the therapeutic process with a single individual. There is the whole area of communicating in the group therapeutic process that I have not touched upon.<sup>10</sup> And then there are what are re-

ferred to as levels of communication and ways of communication. I am using the noun form because that is the way the literature is written. I have felt that sometimes the writer meant communication and sometimes communicating. Those who think more dualistically think in terms of the noun and those who think transactionally feel in terms of the verb.

I want to give one man's view on levels of communication. I emphasize one man's view because in this new and advancing field, there is no finality, nor even widely agreed-upon precepts, or formulations. Bachelard<sup>11</sup> says that man goes through five phases of his thinking about himself and the world, and of course this is what he communicates to others. The phases are 1) primitive realism, 2) empiricism, 3) clinical science, 4) modern science, and 5) advancing science. Bois,<sup>11</sup> who quoted Bachelard, calls them 1) the sensing stage, 2)

the classifying stage, 3) the relating stage, 4) the postulating stage, and 5) the unifying stage.

In both, many terms used in this paper may be noted and it may be asked how come there are so many terms. It is because in this wide-open phase of communication theory each person almost has to invent his own terms and structure. When Bois and Bachelard come to Stage Five, both quote Northrop, primitive magic, the East, and poetry, much as I have done. Ultimately, as I said earlier, we are confronted with consciousness itself. We come full circle. Concomitantly, we are "the unanalyzed, unrationalized sensing experience"—Northrop's pure fact—"where the powerful immediacy of cosmic consciousness transcends the discriminative power of our discursive brain." In the ultimates, we find ourselves confronting ourselves, until duality disappears and there is oneness.

## PART IV—COMMUNING AS THERAPY

I wrote "Life History as Therapy,"<sup>12</sup> not "in Therapy," to focus clearly the fact that we are our history moment to moment—being it, experiencing it, and making it—and that to the extent we are being open to it our experiencing is therapeutic. Likewise, to the extent communing is obtaining, it is being therapeutic, it is functioning as therapy.

For communing to function as therapy, the first essential is that the therapist be aware that communing can and does obtain, be aware of its many forms and the processes by which it is helped to become manifest. For this to obtain the therapist must have had such experiences, be open to more, be aware more will obtain as he is growing, and help them happen to the limited extent that he can, as I have previously described. The greatest help is, of course, an openness and wholeheartedness to their happening. With such experiences, and with faith and confidence in their happening, they will obtain more often in his therapeutic work with his patients and in other aspects of his living. I do not believe

a therapy has been successful unless more, deeper, and wider moments of communing have obtained in the therapy. I have formulated this assertion in other ways, elsewhere. Many times I have said that a therapy that ends without the therapist having grown has not been successful. I have also asserted that a therapy has not attained its optimal objectives if the patient has not been able, in silence, quietness, and stillness, lying on the couch, to have moments of communing. In fact it was in "The Use of the Analytic Couch"<sup>2</sup> that the subject of communing began to come into the foreground of my thinking most clearly for the first time. Reference to communing had appeared here and there for some years before.

The consequences for therapy of feeling and being communing are many. All the changes in the therapist's attitude that follow from it will in time influence the patient's attitudes in many ways. One of them will be in his attitudes toward silence, quiet, and stillness. This is of crucial importance with compulsive talkers who

are terrified of the empty space created, or more accurately, that becomes evident when they stop filling it up with words. Then there are those patients who are compulsively silent. In time they are helped to experience the difference between compulsive and constructive silence.

Some possible outcomes of communing and being silent from the therapist's side confirm their deep, forward-moving values. On occasions after I have been silent, quiet, and still through a session, a patient has come to the next session saying that the previous one had been very meaningful to him and that he had appreciated particularly all the helpful comments I had made. He is startled if I tell him I didn't say a word. After one or several such sessions, when I have been silent, quiet, and still, a patient may report when I next see him, that the last session was valuable to him, that he was aware I had not made any comments, but, nonetheless, he felt I had been very much with him and had been very supportive and helpful. The above instances, though infrequent, are all the more meaningful, and also make my point.

In a measure influenced by the above experiences and because of the importance of a first session, after a long separation, I often remain silent throughout. I am so because I know my patient may be anxious about many things. Also some problems may have come up in the interim that he urgently wants to talk about. Also he will be full of all kinds of happenings and insights he will want to tell me. But beyond all these reasons, which are valid enough to give the patient every opportunity to unburden, tell, share, and communicate, there is one reason I am silent that transcends all these. I want to give my patient and myself full opportunity to come out with all that might interfere with communing, to open up and make possible the resuming of communing, and to find hopefully, in the next sessions, that it was now deeper and wider than when we were last regularly working together.

One consequence of communing obtaining affects how we use the vis-a-vis position and the couch<sup>2</sup> to aid mobility in all di-

mensions of being, which ultimately means still more communing obtaining. An initial period of being vis-a-vis, to give optimal opportunity for experiencing contiguity as separate identities, can, in most cases, initiate a feeling of continuity. When patient and therapist have sufficient experience in both, the use of the couch becomes less threatening and the patient is more able to use it for greater experiencing of continuity and for communing. The patient will also be more available for experiencing the differences in sick and healthy withness and separateness, aloneness and togetherness, as well the felt meanings of silence, quietness, and stillness. Finally, on the couch, in more and more moments of communing, he will come to feel the difference between sick individuality and genuine identity and with this become aware of his expanding boundaries. He will become aware in his depths that one cannot find one's true self, one's new self, without losing one's false self, one's old self.

As I said above, it is the occasional and the dramatic instance that draws our attention to something new and also makes the point. The following is one of those dramatic instances. I had been seeing a man at intervals for a period of years and when I did it was daily and for double sessions. Over the past year there had been periods of shorter and longer silences which were becoming increasingly productive. During them he was becoming able more and more to feel and look at all that was going on in him without trying to run away from it, fight it, swallow it, or distort it. At the end of such a silence he would report to me what had been going on. Once he said it felt like he was down deep inside of himself looking up and watching all the maneuvers his mind was going through. At other times he described himself moving up and becoming his mind looking down and then again feeling himself in his middle looking up. With the productive silences there was more letting go of his automatic check on feelings, particularly constructive ones.

He opened the sessions I will describe with, "I have been quiet this morning, yet

very active. I have been recognizing again and again the sequences of my processes. How I label my feelings good and bad." He related two dreams which contained significant childhood material and which led to a number of associations relating to his childhood. For years in analysis there had been a compulsive preoccupation with certain limited aspects of the past, a tenacious and extensive evasive maneuver. In the silences he had become aware how certain areas of his childhood had been blotted out, and of his difficulty in bringing up anything in connection with these periods. With these awarenesses, more childhood material, quite laden with emotion, began to come to the fore. These two dreams and the associations to them were an expression of it. I will mention only one part of the second dream. It takes place in the house he lived in from the age of seven to fourteen. There are many people there. "I ran past them, urgently looking for a place I could go and rest and be alone and wonder about my problems." There was more to the dream and associations to it. Relating it took about thirteen minutes, following which he became silent.

From the time he stopped talking until he began again, seventy-five minutes elapsed. Thus far during the ninety-one minutes of the double session I had not said a word. The day before there had been a silence of thirty-eight minutes, the longest thus far. From this and other evidences, I felt some kind of climax was building up, about which I was not too clear and with which I did not wish to interfere. During the seventy-eight-minute silence, I noted that about every ten minutes he would hold his breath, then follow with a loud expiration and relaxation. On several occasions during this silence there was partial to total body shaking. This had happened several times the day before on the street and in his hotel room after a deep, earth-shaking insight. Twice during the session his shaking was accompanied by sobs. On previous occasions in the analysis, for a period of over two years, there had been episodes of violent sobbing. Just before he began to talk, he very actively kicked his

legs out as if to shake out the kinks and to stretch them.

He said, "I was seeing a whole picture of you helping me by being silent and then I thought, he is silent. Why isn't he helping me? Do what? For what? Then I saw there is no help, no gods to ask." This took about one minute. He was again silent for about five minutes, following which he began to talk. His words came between violent laughing and crying while his whole body shook.

"All my life I've been trying to prove I need help. Help me exclusively. I can prove it. I need help. I am entitled to help. Everybody should help me. Look how helpless I am. I must have special treatment. See how sinful I am. I must have special dispensation. How weak, how helpless I am. How I have been mistreated and I am entitled to special treatment. I have been shouting that all my life. I shouldn't have to be faced with problems. You should solve them magically. Help me. I can prove I am absolutely helpless. I have no friends. I can prove nobody is on my side. I can prove I have been absolutely helpless. You got to help me. Yes, you God damn well better help me. You stayed silent and through the silence I found out what I have been shouting all my life. I see there have been good reasons for paralyzing myself to prove I am helpless."

I asked, "Do you feel you have found a good, quiet place to rest and wonder about your problems?" I was referring to the segment of one of the dreams I mentioned above. "Yes, I found it, I saw it and I rested. I saw how I demanded people help me exclusively. Help me my way. I can prove it. I can prove it. I can prove it." He was silent for about three minutes at which time I said the session was over. He got up smiled and said, "I guess I can handle it better." I extended my hand which he shook firmly.

Here was one more example of communing as therapy where being silent, quiet, and still on the part of both of us had been therapeutic, where indeed there had been total body participation in conflict, with insight, laughing, crying, total

body shaking, with hanging on and letting go, and changes in respiratory patterns. Already in this paper I have described a number of other instances in which communing and being silent have been the effective therapeutic agent. There was the example of the grandmother with her four-months-old grandson. I mentioned the time the man stood over me threateningly, while I looked at him openly in silence, quietness and stillness, until he became sufficiently relaxed to wonder what he was feeling about me and saying to me. There was the incident of the woman who finally broke down, asked for an extra appointment, came on a week-end, and let go, sobbing and pouring out her venom in front of me. And then the incident in which I crawled under the bed with my patient, at which time not only the patients but my staff felt I had taken leave of my senses.

#### COMMUNING, FREER ASSOCIATING AND ATTENDING

In the example concerning the long silence, I mentioned that this man, at these times, became more able to feel and look at all that was going on in him without trying to run away from it, fight it, swallow it, or distort it. He also described times when he felt himself deep inside of himself looking up at his mind going through all kinds of maneuvers, then becoming his mind, at times being his mind looking down on himself, and then again being inside of himself looking up at and watching his mind in action.

What was so clearly described by this patient has considerable relevance for the nature of free association, attention, therapy, and communing. I say that we are always associating and that we do not and cannot talk about anyone but ourselves because whatever we talk about is in terms of our own perceptions. I also say that the real task in therapy is helping, so that a patient is more and more freely associating. And that means not only asking him to tell us everything he is thinking, but to describe and report all that is going on in him—feelings, thoughts, bodily sensations

—without selection. To keep asking, "What are you thinking?" can be a serious technical error, because it is asking the patient to remain focused on thoughts, logical processes, and reason and is blocking him from becoming more aware of his feelings. In fact, when such a block is there, with considerable pride investment in the supremacy of the mind, asking what the patient is thinking fortifies that pride and not only blocks but dooms the therapy.

In one such instance, for one year, I kept asking, "What are you feeling?" rather than "thinking." The patient responded with what he was thinking. At the end of the year I told him that not once in one year had I asked him what he was thinking. He could not believe that he had been that unaware. Neurotically it hurt his pride and frightened him that he had so little control over his conscious processes; later it became evident he believed he should have control over his unconscious ones as well. I continued asking, "What are you feeling?" for another year. He was now hearing my question but finding he couldn't tell me what he felt; he didn't know what he felt; it was too frightening to be open to what he felt, and besides what he thought was far more important, and I was destroying his demand on himself that he should be a genius.

More and more free association by the patient happens only as the analysis progresses and as he feels more secure in himself and in his relations with his therapist. As he does, he becomes aware that he has wittingly and unwittingly been selecting from what has been coming up in him. I used the expression "what is coming up" in him and often use just those words to a patient. I also say "What's going on in you?" "What's giving?" "What comes?" "What else?" "What more in addition to what are you feeling and thinking?" If I note bodily gestures, changes in breathing patterns or hear borborygmi, I may ask directly about them if the patient has not mentioned them and I feel that he is more available to become more aware of his body.

As a patient associates more and more

freely, he becomes more aware of how he has been selecting, and that with certain things coming up in him he has responded in ways which led to their being omitted, distorted, or presented piecemeal. He becomes aware that he has fled from, fought, or swallowed whole some awareness. Only as he is able more and more to develop, toward what is coming up in him, an absolute objectivity, a passionate neutrality, will he be approaching what Martin<sup>13</sup> defined as the philosophy of the analyst—only in this case it refers to one aspect of the patient toward what is coming up in him. The qualities of that attitude are being unobtrusive, incorruptible, unconventional, non-teleological, respectfully vigilant, and threshold-conscious.

And these are pretty much the qualities inherent in the patient's attention which I shall shortly discuss as the process of attending. As I described it above, he is unobtrusive in that he does not select, distort, fight, swallow or take flight from any of what is coming up in him. He is therefore being incorruptible and unconventional in that he tells all and is non-judgmental. He is non-teleological in that purpose does not influence him. He is respectfully vigilant in that he accords equal respect to all that is coming up in him. He is vigilant. There is a certain tightness and tension about this word, and therefore I prefer two expressions of Krishnamurti, namely, being passively alert and choicelessly aware which, as he put it and I agree, is the height of being active inwardly and outwardly. And now about being threshold-conscious. This will follow and be a consequence of the above attitudes because the patient will describe all that is clear, slightly clear, vague, and that which cannot yet be put into words. Thereby he will become aware of what is ineffable and indescribable. Also he will become aware of how these awarenesses, and what was in the background, subtle and covert, moved into the foreground and became clear and overt. It is the analyst's task in being threshold-conscious to point at what the patient may not be seeing or seeing unclearly for a host of reasons.

While the patient is associating, he is attending to his processes, whatever the qualities of his attitudes toward them. Whyte<sup>14</sup> says, "When the form of any stimulus (either external or internal) is conveyed to and impressed on the dominant organizing processes of an organism, then the *attention* of the organism is said to be directed to that stimulus. Unitary thought uses the term 'attention' where it is necessary to avoid the dualistic implications of 'consciousness.' Attention is not a unique condition or form of reality, but a particular relation either between the organism and a part of the environment or between the organism and a process internal to itself. Attention is a relation which implies receptivity in the organism. . . . Attention is only a transitory focusing of the extended system of processes which guide behavior. It is an inherent weakness of subjective thought that it must misconceive and exaggerate the role of attention."

Although Whyte uses the term attention he clearly means attending, since his emphasis throughout his works is on unitary process thinking. He is out to avoid, undermine, and resolve dualistic thinking, which has been one of my main efforts in this paper. With his statements that attention implies receptivity is a transitory focusing, and that it may be on a process internal or external and prompted by an inside or outside stimulus, I agree. At this point, I am focusing on attending to internal processes mainly internally stimulated.

Schachtel<sup>15</sup> quotes William James' concise formulation, "My experience is what I agree to attend to," and says that it "also stresses the dynamic, motivational character of attention and experience." This is a footnote in the first of a series of articles on "The Development of Focal Attention and the Emergence of Reality." The importance that Schachtel attributes to focal attention is obvious. There are several things he says that are very close to my description of the process of attending and also to what happens as therapy proceeds.

"In the brief outline I have presented of the main structural aspects of focal attention, I mentioned the fact that focal

acts usually consist of several approaches from different angles, and/or renewed approaches from the same angle, to the object, and that these approaches oscillate between receptive exposure to, and active taking hold of the object. . . . It can be observed as easily in focal attention to something visually perceived as in focal attention to a thought or feeling." And about therapy he says, "First, the relationship is designed to lessen anxiety to the point where focal attention, rather than need or fear-driven alertness, can develop sufficiently to enable the patient to see himself. Second, in the transference relationship the patient uses and sees the therapist at first largely as a need-satisfying object and/or as a danger against which he has to protect himself. This perception changes gradually, and to the extent that the patient no longer sees the therapist as a need-satisfying or as a threatening object, the patient becomes able to see the therapist objectively as a person."

I have developed my ideas on freer associating and attending because they are crucial in themselves and for understanding the process of relating and how communing comes about. As a patient moves toward absolute objectivity while attending to the totality of his processes, more and more moments of communing will obtain. This means moments in which there will no longer be an experiencer and what is being experienced. Then we will be intelligent. "Intelligence being the total awareness of our process," says Krishnamurti.<sup>16</sup> Haas points at something similar when he says, "The word awareness might be appropriate to this state. It implies that there can be awareness without anything of which awareness is aware—hence a state of pure lucidity."<sup>17</sup>

#### COMMUNING—STRUGGLING, HANGING ON AND LETTING GO

With freer and freer associating, and attending with more in the direction of absolute objectivity, the patient will experience more of struggling, hanging on and letting go on his way to moments of communing. Also in such situations, what I will, silently,

seems more often to be responded to. After years of fighting lying down on the couch, a woman finally did so. A week later, in a session during which she was lying on the couch, I could feel and see the struggling in her body, the hanging on and letting go. She said after some minutes, "I feel I'm struggling precipitously on the brink of delving. I feel unless I get taken over by forces greater than I am, I won't. It cannot be that way. I have to go along with whatever way it goes." Her words poetically describe struggling, and also where it is going on, "precipitously on the brink of."

A week later she reported that over the week-end she had been having lots of feelings of "I want to, I don't want to" and feelings of despair. During the session there was lot more experiencing of "I want to, I don't want to" in terms of an external situation. She then experienced "a letting go of the external situation" but continued to have the "I want to, I don't want to" feeling unconnected to any external situation or internal feeling, which made those feeling even more painful and distressing.

In the midst of this struggling and letting go she seemed more responsive to my silent wishes. She was sitting facing me the first five minutes of the session. I had the feeling, "I wish she would lie down. It would be better if she did." Within thirty seconds she lay down. Somewhat later, I noticed that she had moved to the surface from her depths, and was thrashing around hanging onto superficials. I had the feeling, "I wish she would stop struggling and making so much noise and listen to herself." Within less than a minute she did just that. After some minutes of talking she stopped. I felt she had come up against some block. This time I had the feeling, "I wish she would sit up and face me. It might start things moving again." Within thirty seconds she turned over on her stomach and faced me. This incidentally was the first time she had ever done this. She had faced me, but not sitting up. I related these three happenings to her. She said she was aware she was making the decisions at the moment she was acting on them, but not that they were in response to my wishing. She added

that she felt me clearly conducting the session, but not any more so at those specific moments.

In the next instance the struggling, the letting go and the suddenly being able are all there. Also there is a reference to running, similar to my own and to the earlier example of the man who suddenly discovered he was no longer afraid and could swim. A woman had been talking about her awareness of feelings of opposing, resenting, resisting, and a shutting down on all feelings. The evening before she had had a discussion with a young man who had been a track man in college. He described the same sensations in running. He said that at first "one feels a great resistance that has to be overcome, and then quite suddenly it's as though the burden falls away." He then has the feeling he is so much at one with himself, he doesn't feel as if he is moving. She quoted him as saying, "It's kind of being and effortlessness." "I know what he is talking about," she said. "It happened with me. I met with resistance. I got so mad and resentful that I felt it was the end. I remember the experience. Then all of a sudden something happens and it comes. I had the same experience with putting nipples on the bottle and thought how am I going to do that. I felt clumsy and now I am aware of an opposition feeling while I was doing it. It was the same with dancing. It didn't come. I wasn't with it. Then all of a sudden something gives way."

#### COMMUNING—INEFFABLE, INDESCRIBABLE

Sometimes before, during, or after experiences moving in the direction of communing, patients spontaneously, or in response to questioning, try to describe their feelings. In view of what I have said about their essential ineffability it might be expected that they would have difficulty in doing so, and that is what happens, as in the following instance.

A man had been in analysis a number of years. One of his crucial neurotic needs was to be always calm, poised, and charming. Also he demanded that the world regard and treat him as the only one, the

preferred one, the darling of the Gods. In previous months these needs were being exposed and undermined, and with this had come increasing experiencing of rage and panic which he was finding more and more difficult to hold in check and hide.

One day, following an altercation with a taxi driver, he came into a session shaking with rage. For the first few minutes he could hardly talk, he shook so much with fury and panic. My efforts were to help him experience as much as he was available for—the intensity of his rage and panic and the sources of these feelings. Toward the end of the session I asked him, "What feelings have you been having with reference to me during this session?" He said, "None specifically while the session was going on. When you asked me the question just now my response was, 'Like a team.' What I mean is, it is hard to put it into words. Like I feel a kind of smoothness, the way we are working today." I asked, "What feelings do you have about working like a team, smoothness and being anxious, as you have been this session?" He said, "Gee, I don't know." I asked, "What about the surprised tone in your voice?" He said, "It would appear to be an inconsistency but I don't experience it that way." In the next sessions he was more relaxed. About the middle of that session he said he was feeling the anxiety he often felt but this time the anxiety was without the feeling of helplessness. A little later he said, "I can't put it into words any more than what I said at the end of yesterday's session. I am still anxious and yet I felt it was a good session."

In this example is the expression 'like a team.' He spoke of the difficulty of putting the feelings of the experience into words, which he mentioned again the following session. The impact of the previous session showed not only in his spontaneously bringing it up due to its being so much with him, but also the effect of it. He was feeling anxious but without the helplessness. This represented a shift in his attitude toward his anxiety and a lowering of the intensity of the anxiety.<sup>18</sup>

Longer and more frequent episodes of

silence had been occurring in another man's analysis and were a mixture of being obstructive and productive. During this session, I did not say a word. He came into the session looking quite frightened and lay down on the couch. The first twenty minutes of his associations dealt with current problems requiring that he make some choices, and a dream of traveling to which he added, "Some sort of feeling of traveling distances inside of myself." Shortly thereafter, "I feel like not being quiet. Make a choice to look into my clearly seeing. I have been quietly, clearly seeing—(pause)—dark in here, too dark." (Silent eight minutes). The feel of this silence to me was of pleasantness, surprise and anxiousness. He ended it with laughing, restlessness, giggling, and patting his hands like a little boy. "I am just feeling the silence. So exciting, everything." He kept laughing with tears streaming down his cheeks. "I just want to hear what I hear inside myself. I wanted to hear it here. Hear it all . . . that I hear." Tears still streaming down his cheeks. "Something I didn't feel before. A feeling of directness from my spinal cord to you, through myself, as if I didn't want to mark it. I just wanted it to be. Feels so good being and it feels so good, exciting. . . . I just like this sense of pure being." At this point he began to giggle and laugh like a child. "It has so much good sort of feeling. It doesn't ask to be good or bad, as it is just there. Integral, wholeness, all these words seem to fit." In between what I have written, and for the rest of the sessions were associations about a choice he had to make, recollections of home and childhood.

In the next session the themes of choice and conflict continued. His body and associations showed he was going through intense struggle. At one point he said, "I wanted to cry out mother." This cry led to an opening up and explorations in the following months of his deepest involvements with his mother. "You being quiet. Dad coming in. You wanted me to feel myself. Feeling you pushed me. Feeling you couldn't push me. It's a matter of decision." He began to chuckle while smiling like a

child. Then he started giggling and clapping his hands like a child. A short silence. "Good feelings. Clear feelings. After pulling away I felt I was looking for a new way of understanding. All of this was the excitement and feeling new ways. I was feeling a new communication. Being right there and communicating right there . . . I felt it with Dad. Feel I wasn't there often. The excitement of feeling the unknown in myself"—laughing and giggling—"I feel almost as though I want to cry. I don't want to either. I want to do everything"—laughing—"Doubting it in a way. Not really. What is it. I do know. I was thinking about Dad. Flowing toward Dad. I was just feeling over-flowing toward him. . . . Feels like a whole sort of new kindness towards myself. I get this feeling of waiting to do something here. I feel all with you. I want to grasp you. Completely unite."

To indicate his feeling communing, this young man used such descriptions as, "A feeling of directness from my spinal cord to you, through myself," "This sense of pure being," "integral, wholeness, all these words seem to fit," "I was feeling a new communication. Being right there and communicating right there," "I feel all with you." The man I described before used the expression "like a team." He explicitly talked of the difficulty of finding words. The young man showed both his difficulty in finding words and his urge to communicate what he was feeling by the many ways he tried to formulate his feelings through two consecutive sessions which were quite crucial. He also responded in the second session with deep awareness and forward moving to my being silent the whole previous session and most of the second.

Some patients, when they have the experience of communing, remain silent, being tongue-tied and at a loss of words to communicate what they are feeling. After a number of years of analysis, a man who had been extremely alienated, not only incapable, but also extremely terrified of moving in the direction of more, deeper and longer relating, began having these experiences during sessions. Most of the time he lay on the couch, but occasionally he

sat up and it was while sitting up that these happenings occurred. More and more often over a period of a year, he would be sitting there, often looking at me and then he would stop talking. I noted he would smile, his face would flush and his eyes soften and at times water a bit. After he would be sitting that way for a minute or two, he would start talking. He often said that he had no words to describe his feelings. Sometimes he said, "It's a flowing toward you and you flowing toward me. It's open. It's smiling. It's loose. It's warm." As he became more acquainted with these experiences they would occasionally last longer. While he was still silent I might ask him what he was feeling, and I would note him swallow, smile more, and turn the palms of both hands up and out toward me. Later he would tell me, "There are no words for what I was feeling," and his gesture indicated it as well as anything. In-

cidentally, he never knew when these happenings might occur nor did I, nor did he know when he would begin to get frightened and cut them off.

These moments of communing, of which I have given instances, are therapy, but also are the steps and forms of those steps along the way. These are the many experiences of letting go. Earlier there was the example of the man who felt a letting-go into the unknown of himself. Then there was the example of the extended silence during which there were many sequences of letting-go and grabbing, followed by the deep realization of what he had been doing all his life and my intent in having remained silent. There was also the example of the man who figuratively and almost literally pushed his father off his chest following which he let go of his shallow chest breathing, and following which it became full and deep.

*To be continued*

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## BOOK REVIEWS

EXISTENCE: A New Dimension in Psychiatry and Psychology. Edited by Rollo May, Ernest Angel and Henry T. Ellenberger. 445 pp. Basic Books, New York, 1958. \$7.50.

Existentialism has permeated the thinking of European psychoanalysts and psychiatrists. This book represents an attempt to give the American reader the translation from the German and French of some of the works of the leading spokesmen for the existential analytic movement: Ludwig Binswanger, Eugene Minkowski, Erwin W. Straus, V. E. von Gebattel, and Roland Kuhn. They are introduced by three general articles, two by Rollo May, "The Origin and Significance of the Existential Movement in Psychology," "Contributions of Existential Psychotherapy," and the third by Henry Ellenberger, "A Clinical Introduction to Psychiatric Phenomenology and Existential Analysis."

In the introduction, May undertakes a difficult task in trying to convey the depth and full range of existentialist concepts. He warns of the loss, distortions and, sometimes, the impossibility of conveying accurate meanings in translations. This in itself is an interesting commentary on the empirical level of psychology and of existentialism in particular. Translations of any of the exact sciences are easily understood because they deal with abstractions which can be quantified and defined in contrast to the necessarily loose empirical terms and formulations that deal with psychotherapy and existentialism.

May emphasizes philosophical considerations in order to clarify what is meant by "existential analysis." The existential movement is not just another school of thought which has deviated from Freudianism. "It is not the creation of any one leader but grew up spontaneously and indigenously

in diverse parts of the continent . . . it does not purport . . . to give a new technique of therapy. . . . It seeks to analyze the structure of human existence . . . which if successful should yield an understanding of the reality underlying all situations of human beings in crises." May feels that existential analysis widens and deepens the basic concepts and understandings of psychotherapy and psychoanalysis.

"Existential Analysis," in this book, refers to Binswanger's school of "Existential Analysis" (in contrast to Frankl's Existential Analysis—comp. Am. J. Psychoanal. Vol. XVIII. No. 1, 28, and Vol. XVIII. No. 2, 194) and its philosophy is based on Martin Heidegger's works (especially *Sein und Zeit*, Halle, Niemayer 1927), which, again, are largely based on Edmund Husserl's works on phenomenology.

In Husserl's sense, phenomenology means an approach to the phenomenon observed with complete lack of bias, that is, seeing it as completely as possible, and only as it manifests itself. This means that the observer excludes from his mind not only any judgment of value but also any affirmation wherever concerning cause or background. He even tries to exclude any distinction between subject and object and any affirmation of the existence of the object and of the observing subject.

The application of Husserl's teachings to psychotherapy was made in two directions, first by placing emphasis on the therapist's own state of consciousness and, second, by the investigation of a patient's subjective states of consciousness. In regard to this investigation, three main methods have been used:

1. Descriptive phenomenology, which relies entirely on a patient's description of his subjective experience.
2. The "Genetic-Structure" method, which postulates a fundamental unity in

an individual's state of consciousness and tries to find this "Genetic Factor" which will enable the doctor to understand his patient's "world."

3. Categorical Analysis, which "takes a system of phenomenological coordinates (the most important of which are time or 'temporality,' space or 'spaciality,' 'causality' and 'materiality')." The investigator analyzes how each of them is experienced by the patient in order to achieve a thorough and detailed reconstruction of the patient's inner universe of experience.

There is no example of descriptive phenomenology. An interesting example of genetic-structural phenomenology is given in von Gebattel's study of the compulsive neurotic. Von Gebattel, distinguishing between "disturbing symptoms" and "warding-off symptoms," shows how the world of the compulsive stems from a particular type of "hampering of self-realization." This world is a "counterworld" of decaying forms and destroying powers against which the compulsive is fighting for survival.

Categorical phenomenology and especially some of its "categories" such as "temporality" (the subjective time of one's own inner experience) and "spaciality" (the subjective space of one's own inner experience) are well demonstrated by Minkowski's paper about a depressive schizophrenic.

"Existential Analysis" uses these three phenomenological approaches to the reconstruction of a patient's inner world. It is "a synthesis of psychoanalysis, phenomenology and existentialist concepts" (mostly Heidegger's), modified by Binswanger's original insights.

Heidegger's *Daseinsanalytik* studies the way in which humans exist (*Dasein*) in contrast to the ways things exist (*Vorhandensein*). He bases his thoughts on concepts of Kierkegaard, stating that man is not a ready-made being but, rather, that he will become what he makes of himself and no more; that he has the drive and the power toward an "authentic modality" of existence (self-realization). Authentic existence is "the modality in which man assumes the responsibility of his own existence. In order to pass from an inauthentic to an authentic

existence, man has to suffer the ordeal of despair and 'existential anxiety'—to face the limits of his existence with its fullest implication: death, nothingness."

Binswanger's merit was that he created a larger framework for psychotherapy than phenomenological studies had provided. He extended his research beyond "states of consciousness" to the entire structure of existence. He extended the individual's "world of existence" into a concept of many "worlds of existence" (for instance, in relationship to the self, to intimate relationships, and so forth).

What are the therapeutic implications of *Daseinsanalyse*? It seems quite clear that its phenomenological approach does not invalidate or interfere with psychoanalytic technique, except that it lessens the tendency to interpret or judge, rather than to observe and experience with the patient the totality of his worlds. The patient-analyst relationship thus becomes an "encounter relationship." Being aware of the different "modalities," the analyst will experience his patient's conflicts and anxieties in terms of temporality or spatiality conflicts. Thereby, according to Binswanger, Manfred Bleuler, and Ellenberger, he has at his disposal a method by which he becomes able to reach patients, especially schizophrenics, who are almost out of reach of any other method of approach. As Bleuler states: "The remarkable result of existential analytical research in schizophrenia lies in the discovery that even in schizophrenia the human spirit is not split into fragments. . . . If the mental life of a schizophrenic as existential analysis shows, is not merely a field strewn with ruins but has retained a certain structure, then it becomes evident, that it must be described not as an agglomeration of symptoms but as a whole and as a 'Gestalt.' Binswanger's two case histories—one of Ilse ("Insanity as Life-Historical Phenomenon and as Mental disease") and one of Ellen West—support and illustrate Bleuler's remarks. The case of Ellen West is given in great detail. She had been treated by two psychoanalysts, and Binswanger discusses how she was understood by the analysts, by Bleuler and

Kraepelin who had seen her in consultation, and how she would now be understood on the basis of existential psychoanalysis.

The book gives additional valuable tools for the understanding and therapy of our patients, especially schizophrenics. Of greater interest and significance is that it seems to parallel the evolution of our psychoanalytic movement. Expressions like "self-realization," thinking in terms of patient-analyst relationship rather than transference-counter transference, and of process, show clearly how the psychoanalytic approach is moving in the direction of phenomenological thinking. Actually, the philosophical ideas used as the basis for *Daseinsanalyse* seem to me so basic and self-evidently truthful, that one may wonder what kept us unaware of them until the last few decades.

—HERBERT ROSENTHAL, M.D.

THE ANALYSIS OF DREAMS. Medard Boss, Rider Co., London, 1957.

An important trend in current psychiatric thinking has been a growing interest in existentialism and phenomenology. This has been more intense in Europe than here; witness that the Fourth International Congress of Psychotherapy (1958) at Barcelona devoted itself entirely to these subjects. There are many understandable reasons for such interest. Our concept of neurosis (and of psychosis, likewise) has changed from a more circumscribed symptomatological one to a more general characterological one, from the person with a sickness to the sick person. The type of illness we see in psychoanalytic practice has changed from a predominance of the more or less clear-cut neurosis to an increasing percentage of the more schizoid or borderline case. We are realizing more and more that no one currently held psychological theory explains all the human phenomena we see, though some may account for more observations more satisfactorily than others, and so may better serve as working hypotheses.

That there has been such a lag in enthusiasm and interest in this country in spite of these awarenesses seems to be due

to two related groups of causes; one inherent in the nature of psychiatric development here, the other inherent in existential theory itself. On one hand, the search for more comprehensive approaches to psychic pathology has taken other roads during the past three decades (while Existentialism was evolving in Europe). We have tended to organize new psychological ideas into "schools," some of which have shifted emphasis while retaining their major tenets, for example, the Freudian from instincts to ego psychology. Others have grown *de novo* around each new theory or psychogenic factor found to play a part in mental illness.

On the other hand, there has been a paucity of comprehensible literature available to the psychiatrist here. Original European work has been written in extremely complex terminology, the meaning of which is often difficult to grasp. This complexity may be inherent in the nature of the concepts themselves, or in the native idiom of the country where written. In addition, the chief impression we have received of existentialism (existential analysis) and phenomenology (*daseinsanalyse*) is that they are either an intellectual philosophy or an abstract, theoretical psychology, rather than applicable clinical therapy with particular techniques.

This is especially true of the Sartrean form, written by a non-medical man, which explicitly states that it is not a psychology, although it purports to "analyze" the psyche and discusses such qualities as "emotions." It basically attempts to define the nature of existence of all objects, therefore including the human being almost incidentally, as another object. And although a good deal of work has been done in phenomenology by psychiatrists, much of it has not been published in English.

This book, an import from England, does much to fill the need for a readable, understandable presentation of existential-phenomenological concepts, which will at the same time bridge the gap between abstract theory and clinical therapy, since dreams constitute an important part of our daily psychoanalytic fare.

The work is divided into four parts. The first is devoted to an historical review, discussion and critique of the various theories of dreams held until now, including the Freudian, Jungian, recent neo-Freudian, such as Fromm, non-analytic theories, and previous phenomenological theories. The second part deals with the dream itself, that is, with the symbolic interpretation of content. Here a particular dream is presented and the various possible interpretative methods are discussed. The third section introduces and describes the various aspects and qualities which the existential-phenomenological approach permits us to see. Finally, a short section considers the dream as a whole, that is, the nature of the dreaming state as compared with the waking state as modes of existence.

Dr. Boss rejects the thesis that dreams must be attributed to a physio-psychological energy (causalist origin) or that they represent an attempt to reach a goal-like aim (finalist origin). Therefore, they do not represent either an instinctual wish-fulfillment (Freud) or a subjective auto-symbolic expression (Jung, etc.). As long as they are viewed within such contexts, the interpretation of symbolic meanings of content are either not valid or are too limited. This applies to any theoretical framework; while such interpretations may be given in practice without harming the patient, they do not permit the fullest understanding of the dream, nor bring to the patient the fullest awareness.

He maintains that interpretations must include all meanings and attributes of the dream object "in its own right," without regard to the analyst's preconceived notion, to the patient's wish to direct interpretations, or to any theory of knowledge. And so, from the viewpoint of its existence in its world, every possible aspect and function of the dream objects will enter into consideration, such as its movement, time, distance, degree, uses, descriptive qualities, and symbolic equivalents. In this phenomenal reduction, dream objects are not symbolic representations of anything within the dreamer; they are himself, describe his very being, his body, his inner life.

Applying the same principles to the dreamer, he will express in his dreams all of his ways of functioning and being. Numerous examples of dreams are given wherein are expressed such phenomena as the making of decisions, volitional or reflective behavior, imagination and vision, conscious thought, lying or making mistakes, artistic appreciation, and moral judgment. These, however, cannot be seen as "psychological functions" in the commonly accepted usage, that is, with all the implications of emotional, mental or motivational forces, but as being-states. In other words, our concepts of neurotic, psychotic, or healthy do not apply insofar as they indicate or include dynamic processes. Nevertheless, it is notable how much these existence-states, albeit in a descriptive, static sense, resemble what we might describe as constructive (healthy) or obstructive (neurotic) qualities—duplicity, responsibility, etc.—in a dynamic sense.

Not only particular phenomena but also total patterns of being, or ways of experiencing oneself and the world, are expressed in dreams. For instance, examples are given of persons whose existence is characterized by total constriction; or by the constant feeling of rush; or by stagnation and the need to set things in movement; or by the belief in magical influences to produce events. Certainly any of these traits corresponds to the observations we all might make about a patient. But we would see it as a neurotic manifestation or solution, resulting from emotional conflict, rather than as an existential world-view.

In considering the dream as a whole, the author emphasizes that dreaming cannot be seen as a state different from or separate from the waking condition. To the dreamer, the dream world is as total and real a state of his human existence as is his conscious (awake) life. It is distorted, symbolized, imagined or paradoxical only as we see it from the outside as observers, and by comparison with what the dream's awake life seems to be. To the dreamer it has none of these qualities; it is as he experiences himself, objects, time, and space.

Although Dr. Boss uses this notion in

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reference to the existential states of being, I feel it can be applied to some of our conventional frames of reference. We might thus say, in Freudian terms, that the dream is not ego-alien, not to be seen as unconscious or as the "return of the repressed"; in terms of inner experience, whatever occurs in dreams is as valid and expressive of inner psychic processes as is the experience of external events while awake; in terms of personality traits, both dreaming and waking states are equally indicative of attitudes toward the self and toward others; in phenomenal terms, both express total world-views (*Wahn*).

Although the book is written in a readable and simple style, one minor criticism is that at times it tends to be rambling

and repetitious. But as regards content, the simplicity is deceptive. On the contrary, this is a difficult book because the basic subject matter is difficult. Much of the discussion deals with fundamental existentialist ideas, whose profundity can truly be appreciated only if the reader has some previous knowledge of phenomenological concepts. The book is certainly a commendable attempt to bring some of these concepts into the realm of clinical psychoanalytic practice, but the average reader would do well to familiarize himself first with the basic existential-phenomenological approach to psychopathology if he wishes to derive a maximum understanding and appreciation of the book.

—JACK L. RUBINS, M.D.

## ANNUAL REPORTS

### The Association for the Advancement of Psychoanalysis

The 1957-58 period saw the attainment of several previously established goals. Within our organization the integration of activities has progressed at an accelerated pace, thanks to the strong interest evinced in common planning of the program. In a sense, the general integration among sciences and humanities took root within our group.

In the Karen Horney Memorial Lecture, Dr. Abram Kardiner discussed "New Horizons and Responsibilities of Psychoanalysis." Societal and anthropological factors were revealed as important tributaries to the main stream of psychological understanding. The lecture, which was preceded by a dinner and social hour, was well attended and a spirit of friendly cooperation prevailed.

An eminent European scholar, Dr. Ulrich Sonnemann, was invited to present an address at the Academy of Medicine. Speaking on "The Human Sciences and Spontaneity," he examined the problem of existential analysis. His talk dealt with the current concern with philosophical concepts and their fundamental value for psychoanalytic theory. By defining the contemporary image of man with greater clarity, one may expect a more effective therapeutic result.

A new research project grew out of the interval meetings that had been set up as workshops the previous year. The material presented at Academy meetings was also worked on at interval meetings. In addition, some members met with me at my home for further discussion.

Another important innovation was the interval meeting with Dr. Suzuki. On this memorable evening the great philosopher introduced us to the Zen Buddhist concept of the unconscious.

As a result of this many-faceted stimulation, it was apparent that communication both within and outside the group was considerably enhanced.

It is good to report that the *American Journal of Psychoanalysis* has increased the number of people on its editorial staff, thereby insuring that a greater variety of viewpoints will be voiced in the future.

During the year there was an increase in regular and associate memberships. A new category of membership also has been proposed.

As usual, ACAAP offered discussion meetings to the public and all were well attended. In the educational field, ACAAP publications found wide acclaim, and are being used as texts in psychology and art classes, especially on the West Coast. Because of the need for mental health education and the importance of the Auxiliary Council's function to the Association, a thorough examination of ACAAP's constitution and its place within our organization and our society will be the next item on our agenda.

In 1957-58 members of the Association participated in many panel discussions and published a number of papers in other professional journals, here and abroad. Familiarity with modern philosophical concepts encouraged a number of members to present papers at the International Congress for Psychotherapy, in Barcelona, where the principal topic was existential analysis.

All the activities of the scientific program were aimed at reinforcing theoretical hypotheses with authentic foundations, so as to bring about speedy and effective help for the patient and generally deepen our understanding of human nature.

We hope that our eagerness to bring to our group and our audience the newest findings in psychoanalysis and allied disciplines will contribute toward their in-

tegration into the standards of our own theoretical and practical equipment and continue to bear fruit.

Antonia Wenkart, M.D.  
President

### American Institute for Psychoanalysis BOARD OF TRUSTEES

Psychoanalytic concepts and attitudes are constantly evolving and with them training programs naturally change in the hope of continuing growth. The Board during its ten meetings of the 1957-1958 academic year considered, revised, and approved recommendations for changes in the training program submitted by the Faculty Council. The full scope and spirit of these changes will appear in the Dean's report of the Faculty Council.

The very active program of the Candidates' Association included two requests to meet with the Board. The two joint meetings that followed resulted in a constructive exchange of views and increased liaison with the Association. The Board noted with great satisfaction the ever-increasing zeal and effort the candidates are showing in their constructive interest in the affairs of the Institute.

The Board certified the following physicians to practice psychoanalysis: Doctors H. Boigon, M. Boigon, D. F. Chirico, W. S. Muhlfelder, R. Slater, R. L. Sharoff, J. Zimmerman.

The Board regrets the passing of one of our colleagues, Dr. Kalman Berke.

#### KAREN HORNEY CLINIC

The Board appointed as Clinical Assistants at the Karen Horney Clinic Doctors Herbert Perr and Sidney Rosen in October, 1957, and Doctors Gerda Willner and Leo P. Frankel in November. In December, 1957, the Board approved changes in the Memorandum of Understanding between the Karen Horney Clinic and the American Institute for Psychoanalysis.

1. The Assistant Medical Director shall be a voting member of the Medical Board if certified, and a non-voting member if not certified.
2. Admission procedures shall be worked

out in accordance with clinic needs by the Medical Board in cooperation with the Technical Committee of the Karen Horney Clinic, Inc.

The Board approved Dr. Sidney Rose as physician-in-charge of the Psychoanalytic Group Therapy Unit. It established a Child Guidance Unit and appointed Dr. Gerald T. Niles as physician-in-charge. Both appointments are to run for one year. A committee was appointed to contact the president of the Karen Horney Clinic to explore possibilities of combining the physical set-ups of the Clinic and the Institute. The Board noted in a letter to Dr. Paul Lussheimer its regret at his refusal of the nomination to be Medical Director of the Karen Horney Clinic:

Dear Doctor Lussheimer:

The members of the Board of Trustees accept with the deepest regret your declining the nomination for Medical Director of the Karen Horney Clinic for the year 1958-1959.

We recall how instrumental you have been in helping make the Clinic a living reality. Your devoted services as Medical Director have not gone unnoticed, for the progress and the interest that the members of the staff have shown is one small indication.

We wish to express our appreciation for your dedicated services and sincerely hope that in the near future you will join us again in the work of the Clinic.

Sincerely yours,

Lester E. Shapiro, M.D.  
Secretary

The Board nominated to the Karen Horney Clinic Dr. Louis R. Hott, as Medical Director and Dr. Louis A. Azorin as Assistant Medical Director. For the Medical Board of the Karen Horney Clinic it selected: Doctors Louis A. Azorin, Dominick A. Barbara, Helen W. Boigon, Melvin Boigon, Harry Gershman, Leon Gottfried, Ada Hirsh, Louis R. Hott, Isidore Portnoy, Jack L. Rubins, Robert L. Sharoff, and Bella S. Van Bark.

At their April, 1958, annual meeting, the members elected Doctors Abe Pinsky,

Isidore Portnoy, and Lester E. Shapiro to the Board of Trustees for the three-year term, 1958-1961.

The Board of Trustees elected the following officers for the year 1958-1959: President—Dr. Nathan Freeman; Vice-President—Dr. Harry Gershman; Secretary—Dr. Lester E. Shapiro; and Treasurer—Dr. Ada Hirsh.

Liaison with Association for the Advancement of Psychoanalysis will be Dr. Ada Hirsh.

A warm and friendly reception was held on September 22, 1957. The Dean, Dr. Harold Kelman, spoke of the oncoming year's activities and reported on his European experiences. This report was in accordance with the Board's resolution of June 12, 1957. The Dean also awarded diploma certificates to Doctors Leon Gottfried, Louis R. Hott, Morris Isenberg, and Jack L. Rubins.

At the October, 1957, meeting the Board expressed its appreciation to Doctors Harold Kelman and Frederick A. Weiss for their excellent written reports on their experiences in Europe regarding psychiatric and psychoanalytic activities.

Doctors Sara Sheiner and Frederick A. Weiss participated in television panel discussions on psychiatric problems.

The Board accepted with thanks the following gifts: Doctors Helen and Melvin Boigon—\$200; Dr. Ada Hirsh—\$100; Dr. Harold Kelman—\$1,000; Dr. Sara Sheiner—Conference table; Dr. Bella S. Van Bark—\$150.

Nathan Freeman, M.D.  
President

#### THE DEAN

Change is inherent in any vital educational program. In recent years processes within and outside of the Institute have found their crystalization in a newly formulated six-year training program. Its content is consonant with developments in psychoanalytic theory and therapy; its creation is an expression of the responsiveness of the Institute to the needs and desires of psychiatrists currently seeking psychoanalytic training; its aim is to main-

tain and enhance the place of the Institute in the psychoanalytic movement.

The history of the evolution of this program reflects the spirit and actual policy which guides the Institute, namely, that of participation by many, of a majority agreement, and of a spirit of experiment. Since its foundation, the Institute has made several major revisions in its training program and many minor ones. They were in response to our acquired experience, changing situations, and the wishes of the members.

Although this program was to go into effect on September 1, 1958, discussion of it by the Faculty Council, Board of Trustees, and the Candidates Association over the past year has already produced a quickening of spirit, an upsurge of enthusiasm, an attitude of eager anticipation, and a mobilization of energies with very obvious, concrete results.

The new course in training is a comprehensive six-year program. Foundation courses are to be completed in the first three years and the advanced technical ones in the last three. Three supervisions will be required, the first to begin in the third year.

"The academic program is designed to give the candidate a grasp of the fundamentals of psychoanalytic theory and practice. Horney's theory of human motivation constitutes the basis of this program. Knowledge and appreciation of the evolution and current developments in psychoanalysis are also considered vital to the candidate's training.

"The position of the Institute is that only an individual who has made considerable progress toward becoming a whole person can do analysis. A deep and extensive therapeutic analysis is, therefore, considered essential."

The happenings of the past year again affirm a basic tenet of Horney's philosophy that "man can change and go on changing as long as he lives" and so can the Institute, to the founding and development of which she contributed so much.

Harold Kelman, M.D.  
Dean

### The Karen Horney Clinic

The work at the Karen Horney Clinic continued in a fashion similar to that of the previous year. Attempts were made to intensify the services and to make improvements wherever the need became evident. Special attention was paid to the intake procedures in order to permit the selection of patients who are qualified for treatment, not only because of their urgent need for therapy but also because of the special character of their condition. Fulfillment of this latter prerequisite is in conformity with the special task of the clinic to serve as training center for the American Institute for Psychoanalysis.

Many other activities of the clinic were put into service to fulfill, as much as this is possible at the present time, the program of working toward the goal of making the clinic a training and research center. In addition to individual conferences between therapists and supervisors and many conferences of both supervisors and therapists with the Medical Director, there were meetings of the whole professional staff and sessions of special groups, especially of the Medical Board and of the members of the Child Guidance Unit, which were devoted to discussions of clinical problems. The vivid interest and active participation in these discussions was most encouraging and indicative of the advantages the clinic offers not only to its patients and the community at large, but to its doctors, social workers, and administrators. All of them benefit in their own way from these meetings and simultaneously experience the group spirit, the concept of working-together, which is indispensable in a project which was created for the benefit of the community and to contribute to progress in the field of psychoanalysis.

It is understandable, in view of the function the clinic has to fulfill for the American Institute for Psychoanalysis, that the Board of Trustees of the Institute and the Board of Directors and Medical Board of the clinic feel strongly that the physical facilities of the Institute and of the Clinic should be combined. A joint committee of

Institute and Clinic are working intensely toward the goal of having a building that will serve both organizations and, if possible, the Association for the Advancement of Psychoanalysis. Though it may take some time before this project becomes a reality, the enthusiasm shown by the board members of the Institute and of the Clinic will help to pave the way and overcome the difficulties which always stand in the path of such a venture.

As reported previously, the turnover of patients is not very great. This is due to the special character of the treatment, which in most cases has to be of long duration. The clinic puts the emphasis in its therapy on quality rather than quantity and on intensity rather than extensity.

The total number of patients treated at any time amounted to about 105. The medical staff consisted of 63 members and the total number of hours for therapeutic services amounted to 9,495. The non-medical professional staff (case workers and psychologist) whose function it is to prepare the material for intake and who work in an advisory capacity if requested by the therapist, spent 4,272 hours in contact with the patients.

One of the essential functions of the Clinic is the dissemination of information, about psychoanalysis in general and about Horney's ideas, on which the Clinic's work is founded. A number of interviews was given to representatives of newspapers and magazines; two of the attending physicians accepted the invitation of a television network to appear on its programs; lectures were offered to the Auxiliaries of the Clinic. A special new feature was the invitation extended to staff members of various hospitals to attend the medical staff meetings. This innovation was favorably received by the invited doctors.

There remains only thing to be said in this report: the existence of the Clinic depends on the good will of so many people, the doctors who donate not only their time but also show unceasing interest in the growth of the Clinic; the directors and members of the Karen Horney Clinic, Inc., who with admirable energy and great

generosity are helping the Clinic financially as well as with most valuable advice. All of them deserve a vote of thanks for their unselfish devotion.

Paul Lussheimer, M.D.  
Medical Director

### Candidates' Association

Continuing for the second year the successful elimination of Sunday meetings, five meetings were held on Wednesday evenings in the homes of various members. At an additional five meetings, the Executive Council attempted to deal with administrative details, referring only essential matters to the membership for general deliberation. Meeting at the homes of members offered an appropriate setting for the blending of social and professional interests, since refreshments were served before the scientific sessions, business was kept to a minimum, and the bulk of the evening was devoted to scientific considerations.

Although, as in the previous year, clinical matters were considered central, emphasis this year has been on exchanging ideas and points of view with other psychiatrists and allied workers, in an effort to enrich our effectiveness as therapists. In November, we discussed a paper on research in schizophrenia by one of our members who had previously published his results; in February a meeting was devoted to the history of American psychoanalysis; in March, to an anthropological paper on homosexuality by a visiting professor of

anthropology, and in April to newer developments in therapy. The March meeting, which was open, was attended by a considerable number of non-member psychiatrists and physicians.

Following the examples of the winter sessions of the Academy of Psychoanalysis and the American Psychopathological Association, in which analysts from various institutes participated, plans were formulated for a meeting on the candidates' level with at least one other institute in the city, with the hope that other such meetings will be planned for in the future.

During this past year many members contributed to the success of our scientific programs. The Bulletin published several original articles, in addition to extensive reports of Academy, Interval, and other meetings. Individual candidates continued to contribute to the *Journal*, and to be active in the Institute's teaching program. Many candidates continued to staff the Clinic.

A joint meeting of a committee from the Candidates Association and the Board of Trustees was held in December and, at a follow-up meeting in June, significant changes in the curriculum and related matters were announced by the Trustees.

The annual dinner-dance in June and the later picnic at High Point Hospital completed a year of enthusiastic and fruitful effort by members of the association.

Jason Miller, M.D.  
President

## KAREN HORNEY AWARD

THE ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOANALYSIS wishes to announce that the recipient of the first Karen Horney Award will be presented with the Award on the occasion of the Annual Karen Horney Memorial Lecture. The Award, in the amount of \$150, is made for the paper which is deemed to have made a contribution to the furtherance of psychoanalysis. The Award Committee is evaluating current entries for the Award which will be made in March, 1960. Authors who wish to enter their papers for the year 1960 should do so no later than October 1, 1959. All entries should be forwarded to: Louis E. DeRosis, M.D., Chairman, Karen Horney Award Committee, 815 Park Avenue, New York 21, New York.

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